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Executive Summary

September 27, 2013

Attached is the second annual report for VA START. All Advisory Councils reviewed the report that follows as part of the process. In the first full year START operations, well over 500 individuals received services through VA-START. Occupancy rates at the START Centers for Regions 1, 2 and 3 grew over time, and continued to grow in the beginning of FY2014 (Region 2 had a significant jump in this first quarter as noted in the report). By June 30th, all but region 5 provided mobile in home supports. Regions 4 and 5 still do not have START Centers operating, but they are aggressively working toward fall 2013 openings. Region 3 continued to take the lead in all areas of development and operations. However, other regions also made significant progress.

Of great import, VA now has a statewide 24 hour mobile crisis response and all programs have had significant impact on their Regions with an average face to face evaluation response time of less than 2 hours statewide, and immediate telephonic responses through their on call systems. In this first year of operations, 66% of the population seen by VA START while in crisis received either in home supports or were able to return home without supports. This number will improve further as the system matures. In addition, while all regions but 5 provided mobile in home emergency and planned supports for crisis intervention by the end of FY 2013, all provide this service as of September 2013.

Challenges in leadership and workforce development have hampered progress in Regions 1, 4 and 5. However, there are plans in place toward significant progress in all three regions. With Region 3 acknowledged as fully operational and moving in the right direction, it is important to note that all including Regions 4 and 5 are also making progress.

Despite challenges in other areas, Region 4 has consistently maintained a very effective mobile crisis response. Proper Assessments promote appropriate treatment and are therefore key to helping prevent crises and provide effective services. We are pleased that both Regions 2 and 3 were the first in the state to go through the START Certification Process. Region 2 also works very closely with a specialty clinic provided by Dr. Sherer. The clinic provides assessment and treatment and support to community providers.

Despite its challenges, Region 1 has continued to operate fully and has served a significant number of individuals both in and out of their START (respite) Center. Their Medical Director has been very instrumental in supporting individuals with very complex needs.
While Region 5 is still building its operations, Dr. Burkett has stood out as a leader and has assisted in her participation of certification for VA coordinators statewide, as well as National CETs. Region 5 has provided training and CETs in increased numbers.

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Following is brief outline of recommendations provided in greater detail in the full text of the report:

1. It is recommended that the state consider the development of a specialty inpatient service that can work with VASTART to fill in that gap. While the goal is to prevent the need for these services, it will in fact sometimes be needed.

2. Greater focus on training day program and residential providers who serve the dual-diagnosed population along with ongoing consultation and support to these providers through the VA START teams.

3. There needs to be clarification statewide about the role of case managers working the START Coordinators. The program relies heavily upon active and ongoing collaboration.

4. Satisfaction surveys should be conducted for trainings, and all VASTART services

5. The development of a START Center Advisory Group made up of families, guests, and some other stakeholders.

6. The START National Center works with licensing and QA service to insure that START programs comply with licensing, and that licensing promotes the fidelity of the START programs.

7. CETs are conducted in each region monthly.

8. START teams participate in trainings to help support children and transitional youth so that they can link with the new supports now in development for children in Virginia. Our goal is to train the VA-START teams so that they will be better able to assist with service planning and crisis supports for the child population as needed and determined by each region as the system moves forward in this area.

Systems change is complex and sometimes messy. However, VA has a committed group of CSBs, partners and providers dedicated to this mission, and we are please with progress made. Despite bumps in the road and challenges faced, we have a crisis response statewide, and all of the teams are progressing. On behalf of Dr. Weigle, Linda Bimbo and the entire UNH/IOD START Center, I want to thank you and all involved for the opportunity to do this very important work.

Joan B. Beasley, Ph.D., Research Associate Professor
Director, Center for START Services

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VA START Annual Report
July 1, 2012-June 30, 2013

Introduction

This is the second year, and the first full year, of START implementation in the state of Virginia. This report provides analyses of statewide trends from July 1, 2012-June 30th 2013. In addition, each region has developed a separate analysis provided in the addendum to this report. The data set is still small but growing and we expect that future reports will allow us to learn more about the effectiveness of the program. Despite some disappointment with regard to outcomes to date in some regions of the state, there is evidence from Region 3 that the model can be used successfully. Region 3 has worked closely with the Center for START Services and their local partners to develop the best program possible, and the results have been exemplary. That is not to say that there is not room to grow, but Region 3 represents what is possible statewide. Regions 1 and 2 have also shown some promise although their impact this year has been very limited in scope.

While the VASTART program helped to fill some of the gaps in the system, it also helped identify gaps that continue to be in place. These include the need for better inpatient mental health supports for the IDD population need them, alternative services for those with more complex needs who cannot benefit from traditional mental health services, improved partnerships across the board within regions, and better designed and trained residential and day program services for some of the individual being served by VASTART. In addition, better use of Advisory Councils is needed. They are not intended to monitor the programs but rather to assist in their development. It is unclear that they are currently being used effectively across the state. In addition, the lack of affiliation and linkage agreements may help to explain why there continues to be confusion with regard to roles and responsibilities in the system. Recommendations at the end of this report include these and other issues that have become apparent as we have moved ahead in program implementation.

Despite many of the challenges and the work to be done, much has been accomplished and continues to be accomplished. We at the Center for START Services see great promise in the teams we have had the privilege to work with. They are dedicated, hardworking, and very committed to providing the best services possible. We congratulate them on their accomplishments.

What follows is analysis of statewide trends. As discussed, individual regional outcomes are also provided at the end of this report. The regions wrote their own regional reports.

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Client Data

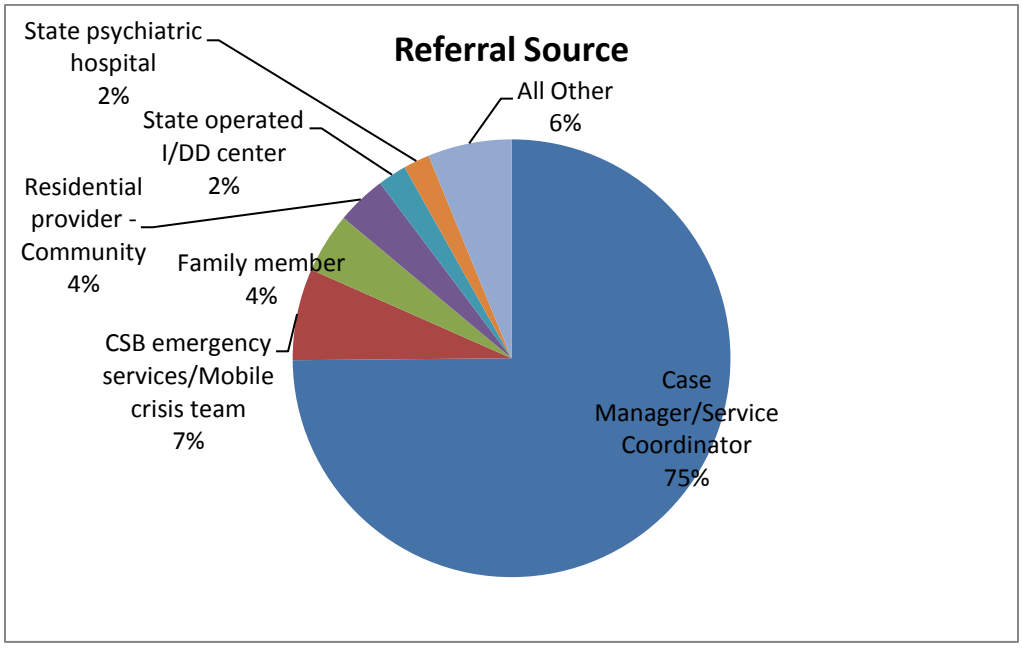
The following data reflects client records entered into the START Information Reporting System (SIRS) for FY 13 (July 1, 2012-June 30, 2013) across all five regions and provides key information about the population served by VA START.

Total Referrals

Region	Number of individuals referred to START in reporting period	Percent of Statewide referrals
Virginia - Region 1	129	24.95%
Virginia - Region 2	94	18.18%
Virginia - Region 3	114	22.05%
Virginia - Region 4	90	17.41%
Virginia - Region 5	90	17.41%
Total	**517**	**100.00%**

Referral Source

The following chart shows the most common referral sources to START. The majority of referrals statewide (75%) came from case managers/care coordinators with emergency service personnel making up the next highest source of referrals.



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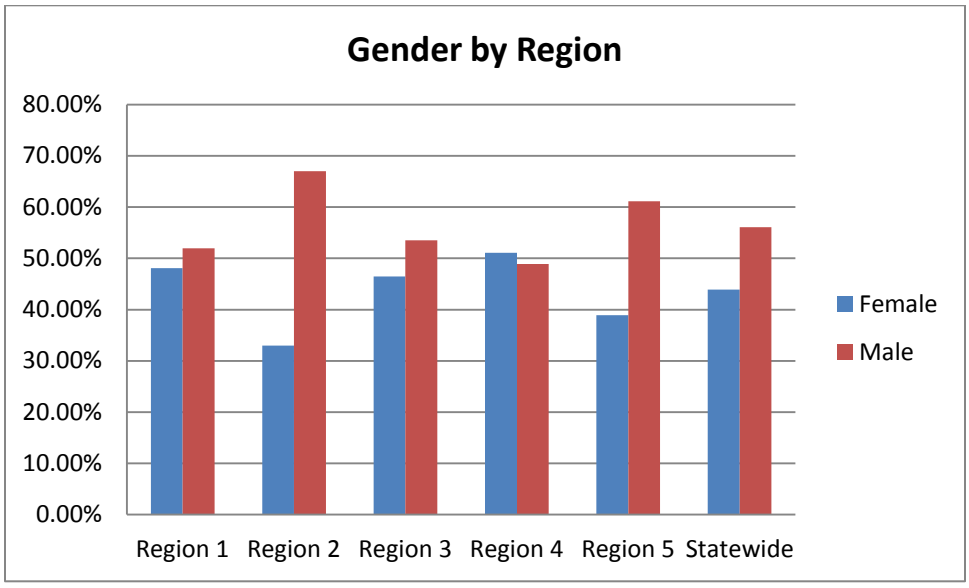
Gender

Gender	Number	Percent
Female	227	43.91%
Male	290	56.09%
Total	**517**	**100.00%**

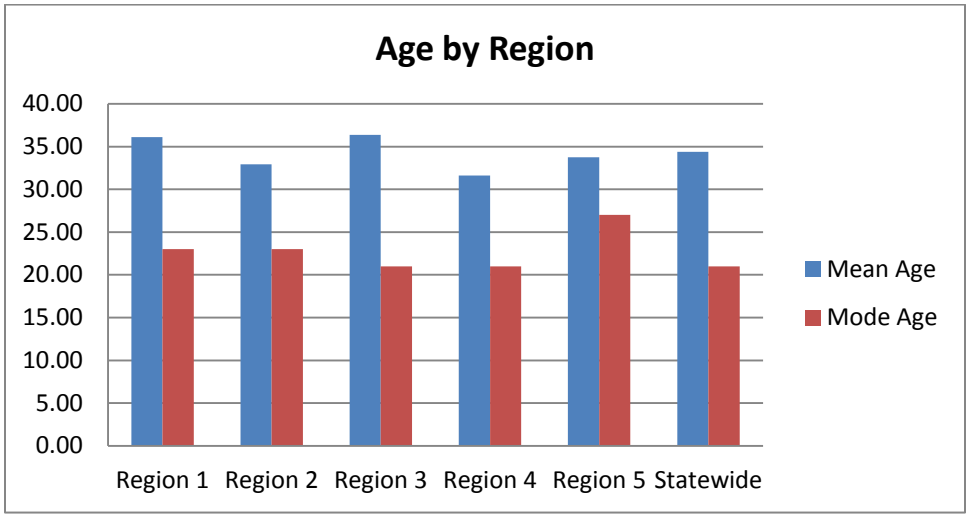
Across the state males make up 12% more of START users. This is reflected in all regions except Region 4 which is roughly equal with the largest disparities occurring in Regions 2 (34%) and 5 (22%).



Age

Age	Descriptive Statistics for individuals by Age
Oldest Age	78
Youngest Age	18
Mean Age	34.39
Median Age	30
Mode Age	21

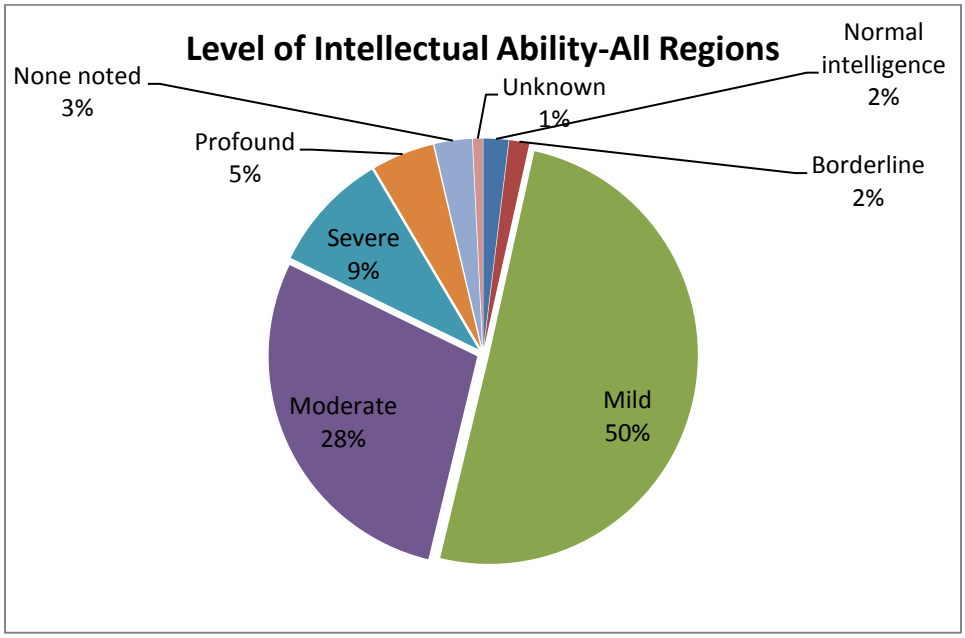
The age range of referrals was 18-78. The mean or average age is 34; the median age was 30; and the mode or most common age reported was 21. The mode age decreased slightly from last reporting period (down from 22) with the transitional youth population more often referred to START for assistance.



Level of Intellectual Disability

As expected, the predominant number of persons referred has mild intellectual disability (50%), followed by moderate ID (28%), severe ID (9%) and profound ID (5%). This trend is consistent across all regions of the state. The population continues to be more disabled than the general population of service users and the newest referrals are more disabled than in the last reporting period with increases in the severe and profound groups and a drop in the mild group from 53% to 50% of the population. In addition, 5% of individuals referred do not have a diagnosed intellectual disability. Since you must have a developmental disability to meet the criteria to be admitted to START, it is likely that this group represents the DD population that is not eligible for ID services. This is a slight decrease from the last reporting period.

Level of Intellectual Disability	Number of Individuals by level of ID reported	Percent of Individuals by level of ID reported
Normal intelligence	10	1.93%
Borderline	8	1.55%
Mild	260	50.29%
Moderate	147	28.43%
Severe	48	9.28%
Profound	25	4.84%
None noted	15	2.90%
Unknown	4	0.77%
Total	**517**	**100.00%**

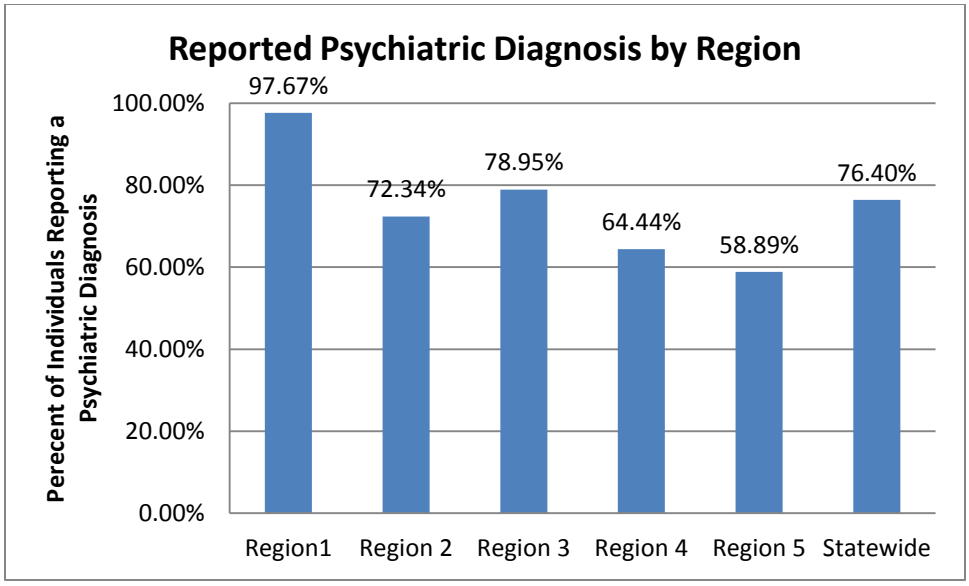


Mental Health Diagnoses at Time of Referral

Psychiatric Diagnoses	Number of individuals reporting a psychiatric diagnosis	Percent of individuals reporting a psychiatric diagnosis
Individuals with reported psychiatric diagnoses	395	76.40%
Total individuals reporting no psychiatric diagnosis	122	23.60%
Total	**517**	**100.00%**

Number of Psychiatric Diagnoses Reported	Number of individuals with this number of psychiatric diagnoses	Percent of individuals with this number of psychiatric diagnoses
Mean diagnoses reported	1.76	N/A
Mode diagnoses reported	1	N/A
1 diagnosis reported	189	47.85%
2 diagnoses reported	128	32.41%
3 diagnoses reported	63	15.95%
4 diagnoses reported	13	3.29%
5 or more diagnoses reported	2	0.51%
Total	**395**	**100.00%**

Of the 517 individuals reported in SIRS for FY 13, 395 (76%) report at least one mental health diagnosis and over half of these (52% statewide) report more than one psychiatric diagnosis. There is a wide disparity by region in the percent of individuals reporting a psychiatric diagnosis with a high of 98% reporting a diagnosis in Region 1 and only 59% reporting a diagnosis in Region 5. For those individuals reporting no diagnosis (23% statewide), it seems likely that mental health services are not being accessed as needed or are being underreported in some regions since nearly 100% of the population is being treated with psychoactive medications.



The following table shows the number and percent of individuals statewide reporting a diagnosis in a particular diagnostic category.

Psychiatric Diagnoses	Number of individuals reporting diagnosis	Percent of individuals reporting diagnosis
Anxiety - all	96	24.30%
Autism - all	88	22.28%
Childhood - all	58	14.68%
Mood - all	166	42.03%
Psychotic - all	98	24.81%
Adjustment disorder	16	4.05%
Eating disorder	1	0.25%
Fictitious/Somatoform	4	1.01%
Impulse control disorder	51	12.91%
Personality disorders (Axis II)	27	6.84%
Sexual/Gender identity	0	0.00%
Substance abuse disorder	6	1.52%
Other	56	14.18%
	395	

The distribution of diagnoses is not surprising and is consistent with other START populations in the U.S. Where the primary issues are mood and anxiety disorders.

Other Disabilities at Time of Referral

The table below indicates the number of disabilities reported in SIRS for the population of START service users. A total of 64 individuals reported disabilities in addition to IDD and mental health diagnoses. Of those individuals, 22% have hearing impairment, 41% have communication and speech problems, and 20% report vision problems. It is hoped that more attention to these important vulnerabilities in the population will be given in future reporting and planning.

Other disabilities	Number of individuals by current disabilities reported	Percent of individuals by current disabilities reported
Hearing	14	21.88%
Physical	4	6.25%
Smell	0	0.00%
Speech/Communication	26	40.63%
Vision	13	20.31%
Other	7	10.94%
Total	**64**	**100.00%**

Medical Diagnoses at the Time of Referral

Medical issues are important to address in the population and other research suggests that they are often underdiagnosed or underreported. Only 54% (N=280) of the service users have reported medical conditions in the SIRS database to date. Of those individuals, half have more than two chronic medical conditions. This is significant given that the most common age of START participants in only 21 and mean age is in the middle 30's. Over 40% of individuals reporting a medical condition report neurologic conditions (seizure disorder), followed by several conditions often associated with psychiatric medication side effects including GI problems (25%), Type 2 diabetes (14%), and cardiovascular disorders (18%).

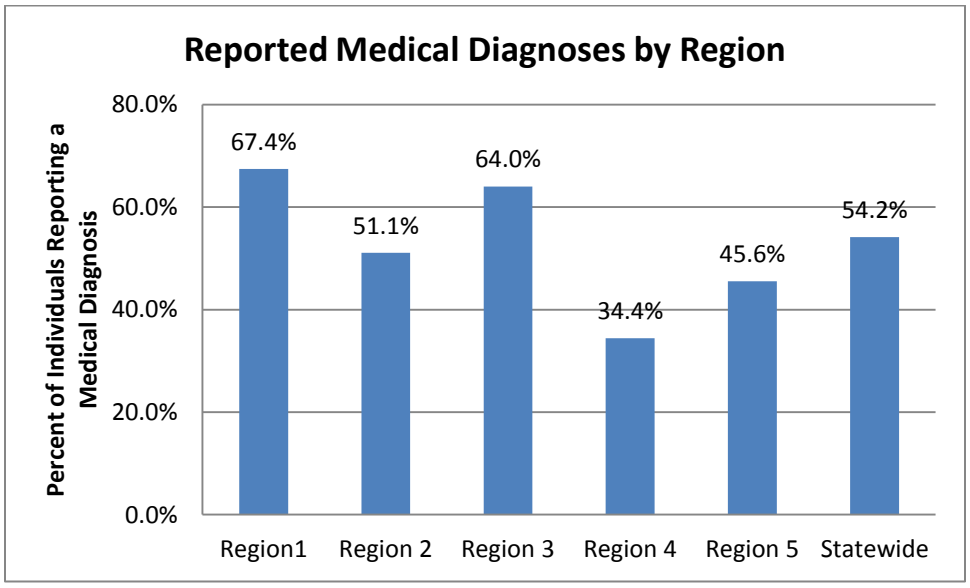
As with the diagnosis and reporting of psychiatric disorders, there are also some differences noted in the percentage of individuals with reported medical conditions in each region. In region 1, over 67% of the START population report a medical condition, while both Region 4 (34%) and Region 5 (46%) report a much lower frequency of medical conditions.

The START team will be using the MEDs and other assessments to better monitor medication effects and educate providers on common health conditions and the effects of chronic medical conditions on the psychological well-being of service users. It is expected that this will be a focus of the services provided by START teams as we move ahead with this project.

Medical Diagnoses	Number of individuals reporting a medical diagnosis	Percent of individuals reporting a medical diagnosis
Individuals with reported medical diagnoses	280	54.16%
Total individuals reporting no diagnosis	237	45.84%
Total	**517**	**100.00%**

Medical Diagnoses Reported	Number of individuals reporting this number of medical diagnoses	Percent of individuals reporting this number of medical diagnoses
Mean diagnoses reported	1.89	N/A
Mode diagnoses reported	1	N/A
1 diagnosis reported	140	50.00%
2 diagnoses reported	75	26.79%
3 diagnoses reported	39	13.93%
4 diagnoses reported	15	5.36%
5 or more diagnoses reported	11	3.93%
Total	**280**	**100.00%**

Medical Diagnoses	Number of individuals reporting diagnosis	Percent of individuals reporting diagnosis
Cardiovascular	50	17.86%
Dental/Oral	5	1.79%
Dermatology/Skin	10	3.57%
Ear/Nose/Throat	12	4.29%
Endocrine	40	14.29%
Eye disorders	16	5.71%
Gastro/Intestinal	70	25.00%
Genitourinary	10	3.57%
GYN/Pregnancy	6	2.14%
Hematology/Oncology	6	2.14%
Hepatic/Biliary	6	2.14%
Immunology/Allergy	23	8.21%
Infectious disease	5	1.79%
Neurologic	113	40.36%
Nutritional disorders	13	4.64%
Pulmonary disorders	33	11.79%
Other	86	30.71%
	280	



Residential information

An important factor that contributes to or undermines mental health stability for service users is a stable home life. As noted in the data, family members and caregivers frequently express concerns about their ability to safely support their family member in the home, especially during times of difficulty (see Emergency Contact section). This same concern also frequently leads to multiple residential placements for the 66% of individuals not living with their families. This lack of permanence is another factor that needs to be explored and may contribute to the underreporting of other critical issues, such as medical problems, since caregivers may lack critical knowledge when placements change frequently. For the entire START population reported in SIRS, over 35% report multiple residential placements in the last five years. This percentage is likely greater, since 34% of the population has never had a residential placement and remained at home.

Multiple residential placements over the last 5 years (at point of referral)	Number of individuals with multiple placements	Percent of individuals with multiple placements
No	334	64.60%
Yes	183	35.40%
Total	**517**	**100.00%**

The table below presents a frequency distribution of residence at the time of referral. This finding indicates that with regard to community housing, the VA START program continues to be on target in supporting families (34%) or people who reside with few paid supports (an additional 7%).

Living situation at time of referral to START	Number of Individuals by type of living situation reported	Percent of Individuals by type of living situation reported
Assisted Family Living (AFL)	18	3.48%
Community ICF/MR	3	0.58%
Family home	176	34.04%
Foster care home	9	1.74%
Group home	208	40.23%
Homeless	3	0.58%
Independent living	14	2.71%
Jail	0	0.00%
Psychiatric hospital	18	3.48%
State operated I/DD center	15	2.90%
Supervised apartment	8	1.55%
Supported living	12	2.32%
Other	17	3.29%
Not Reported	16	3.09%
Total	**517**	**100.00%**

There is a need to receive more referrals prior to moving so that START programs can be better able to assist in transitions. To date less than 10% of the population is referred from state operated centers, hospitals and other facilities. This is expected to increase over time.

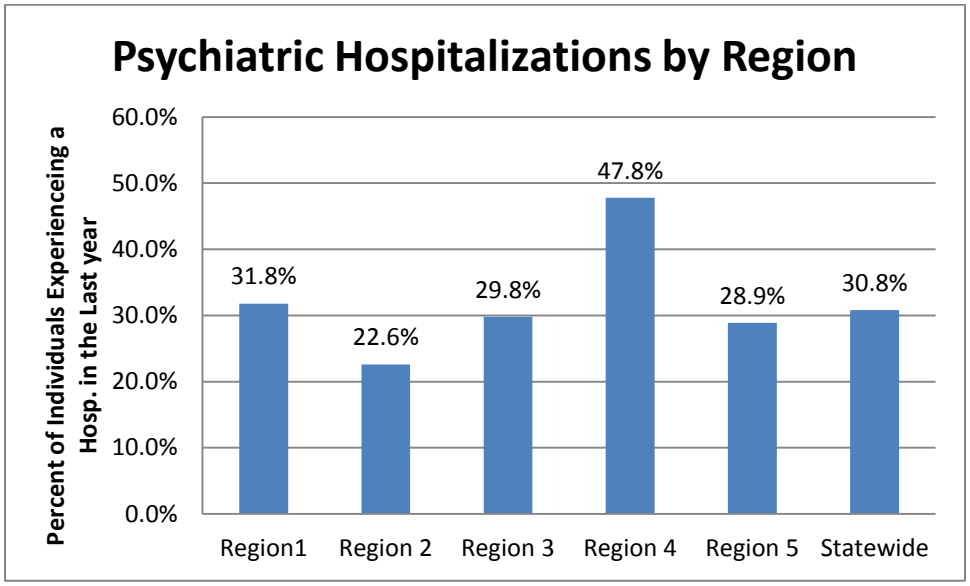
Psychiatric Hospitalizations

As would be expected, a significant number of START service recipients have been admitted to psychiatric hospitals in the past year(35%) with multiple admissions (an average of 2 admissions per client). When reviewing the prior five years, the number of people hospitalized increased by less than 4%, however, the range of number of admissions doubled at the high end. This indicates that likely the same individauls are experiencing frequent hospitalizations. A target goal of the START Program is to help avoid unnecessary hospitalizations and reduce recidivism rates.

Once again, there are some differences noted among the state regions. Region 4 has a psychiatric hospitalization rate that is 17% higher than the average statewide rate, while Region 2 has a rate that is 8% lower. Some of these disparities may be related to the location of hospital facilities or the availability of other mental health support services, and the level of training and expertise with the population in the context of the provision of IDD services.

Psychiatric hospitalizations in the last year (at point of referral)	Number of individuals reporting one or more hospitalizations in the last year	Percent of individuals reporting one or more hospitalizations in the last year
No	357	69.05%
Yes	159	30.75%
Unknown	1	0.19%
Total	**517**	**100.00%**
Range	1-15	
Mean	2.03	

Psych hospitalizations in the last 1-5 years (at point of referral)	Number of individuals reporting one or more hospitalizations in the last 1 - 5 years	Percent of individuals reporting one or more hospitalizations in the last 1 - 5 years
No	340	65.76%
Yes	176	34.04%
Unknown	1	0.19%
Total	**517**	**100.00%**
Range	1-30	
Mean	3.34	



Presenting Problems

As expected, the primary problem reported at referral to START services was some form of aggression (77%). This was followed by mental health symptoms (55%), risk of losing placement (27%) and the family in need of assistance (27%). The majority of individuals reported multiple concerns at time of enrollment with the average number of problems reported 3.

Presenting problems at time of referral	Number of Individuals Reporting Problems	Percent of Individuals Reporting Problems
Aggression - all	398	76.98%
At risk of losing placement	143	27.66%
Decrease in ability to participate in daily functions	97	18.76%
Diagnosis and treatment plan assistance	75	14.51%
Family needs assistance	138	26.69%
Mental health symptoms - all	282	54.55%
Other	89	17.21%
Self-injurious	124	23.98%
Transition from hospital	38	7.35%
Total	**517**	

Case Example

The following vignette exemplifies how START services have impacted one person whose mental health and behavioral challenges had resulted in multiple residential placements, and at the time of referral was threatening his current residential support system. John is an individual that the Region III START Program has been working with since they began services in the summer of 2012. He is 45 years old and diagnosed with Impulse Control Disorder, NOS; Obsessive Compulsive Disorder; Adjustment Disorder, Unspecified; and Moderate Intellectual Disability. Over the past year of working with John and his system, he has struggled with multiple issues, including physical and verbal aggression towards his providers, losing three different housing placements, and two psychiatric hospitalizations.

START has worked with John's system to provide support in multiple ways. We have provided in-home respite support on multiple occasions, cross systems crisis prevention and intervention planning, training center discharge support, assistance in transitioning to new housing, and facility based respite support. John recently transitioned from the respite facility into a new group home. Since that time, START staff has been at the home daily, providing behavioral support, updating the cross systems crisis prevention and intervention plan to reflect his new home and system, and providing support and training to his new staff. Although John's transition to his new group home has not been without some bumps, START has been able to work collaboratively with John, his support coordinator, new residential providers, and his guardian in order to assist in making his new housing placement successful and an enjoyable experience for him.

START Service Outcomes

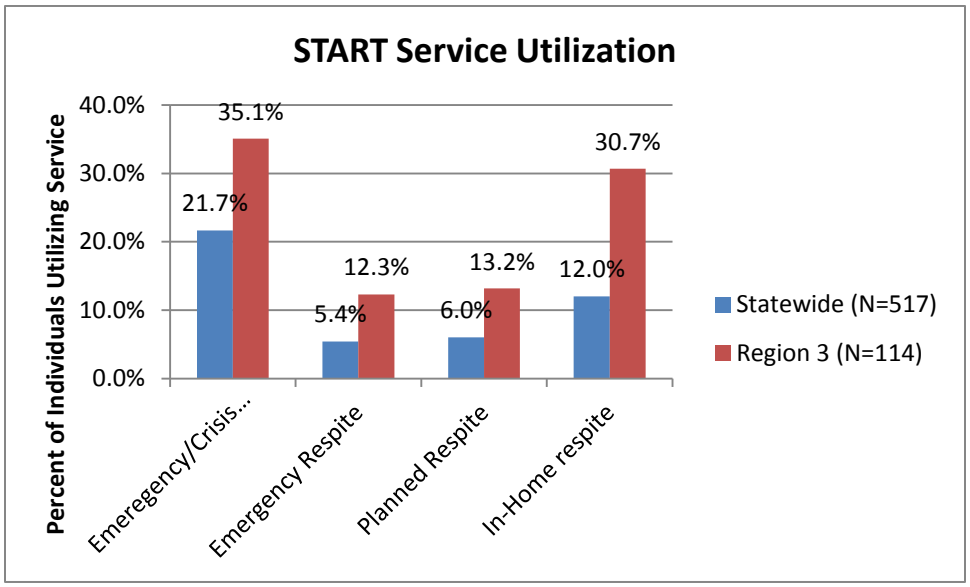
This next section reflects the outcomes of START services across the state. Because Region 3 is reporting on the full array of START services over the entire year, it serves as a comparison for the statewide data.

START services in Virginia include training, consultation, comprehensive assessment, treatment planning, and service linkages as well as support in four primary service areas: Emergency/Crisis Services, Emergency Respite, Planned Respite, and In-Home Respite. The following analysis looks at utilization patterns in each of these services across the state and in Region 3, which has implemented all services areas.

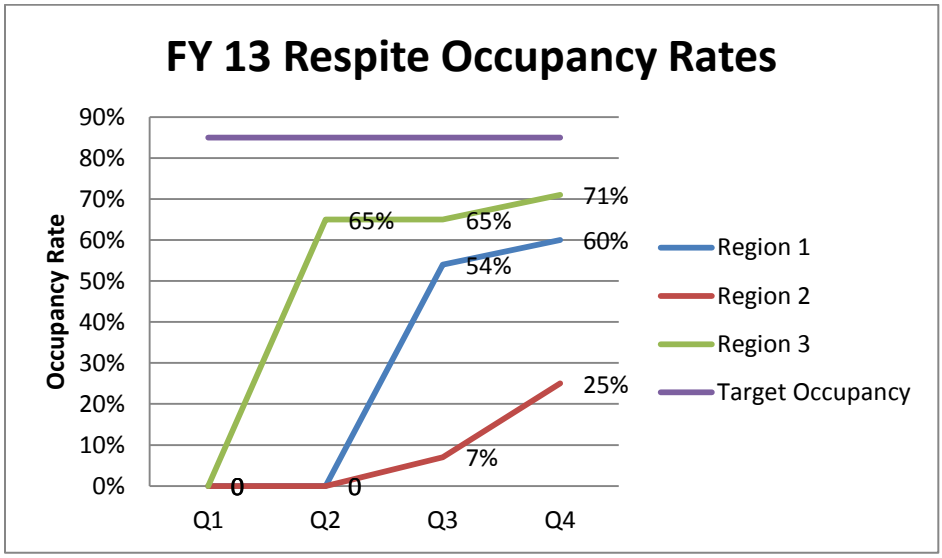
Service Area	Number of Individuals Receiving Service	Percent of Individuals Receiving Service	Average Number of Contacts per Person
Emergency/Crisis Services	112	21.7%	1.7
Emergency Respite	28	5.4%	1.3
Planned Respite	31	6.0%	1.8
In-Home Respite	62	12.0%	3.6
Total START Service Recipients	**517**		

The graph below shows a comparison of the statewide service utilization rates and those in Region 3. In all areas, the utilization in Region 3 is much greater than that statewide. Since Region 3 has the most

established services, we would expect utilization rates to increase markedly as the other regions work to further develop these services. Region 3 demonstrates the capacity of the program that should be reached statewide after one full year of implementation.



Both emergency and planned respite services are START Center-based programs. In Regions 1, 2 and 3 where these programs have begun operations, there has been a steady increase in the occupancy rate at each site. The target occupancy rate for respite programs in FY 14 is 85%. As seen in the graph below, Region 3 which is the most established program is approaching that target after only three quarters of operations. Region 1 had a very strong start of operations in quarter 3 and has continued to increase, and Region 2, which began operations very late in quarter 3 of the fiscal year, has also shown a steady increase in occupancy. Of note, in the first quarter of 2014 fiscal year (July 1-September 30), occupancy at Region 2 respite jumped to 66% of available beds in that period. The complete first quarter report will be out in late October.



The following are key outcomes related to each individual service area.

Emergency/Crisis Services

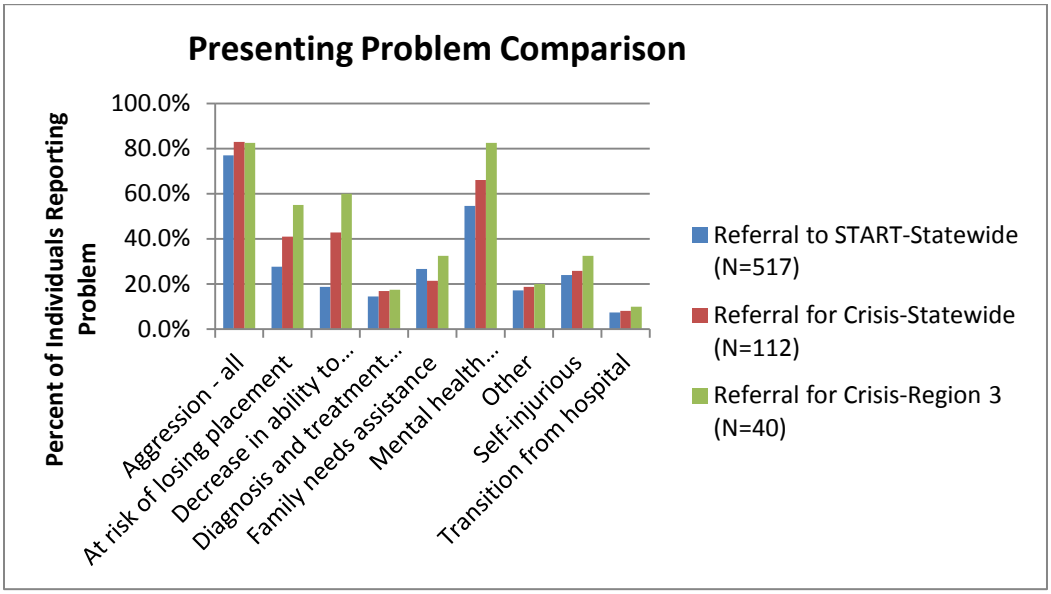
As indicated above, there were 112 individuals served in Emergency/Crisis services across the state.

Presenting Problem

Presenting problems at time of referral to emergency/crisis services	Number of Individuals Reporting Problems	Percent of Individuals Reporting Problems
Aggression - all	93	83.04%
Mental health symptoms - all	74	66.07%
At risk of losing placement	46	41.07%
Decrease in ability to participate in daily functions	48	42.86%
Diagnosis and treatment plan assistance	19	16.96%
Family needs assistance	24	21.43%
Self-injurious	29	25.89%
Transition from hospital	9	8.04%
Other	21	18.75%
Total Emergency Services Service Recipients	**112**	
Total presenting problems	363	
Average # of Problems Reported	3.2	

The presenting problems reported at referral to crisis services are consistent with the presenting problems reported at referral to START in general. Aggression is still the leading problem at referral (83%) followed by mental health symptoms (66%). Of particular note is the marked increase in individuals reporting a decrease in their ability to participate in daily activities (43%). This is up 24% from that reported at referral to START. An important element of crisis services will include exploring the reasons for this decrease in daily functioning (medical conditions, increased psychiatric symptoms, changes in routine, etc.) as factors leading to crisis.

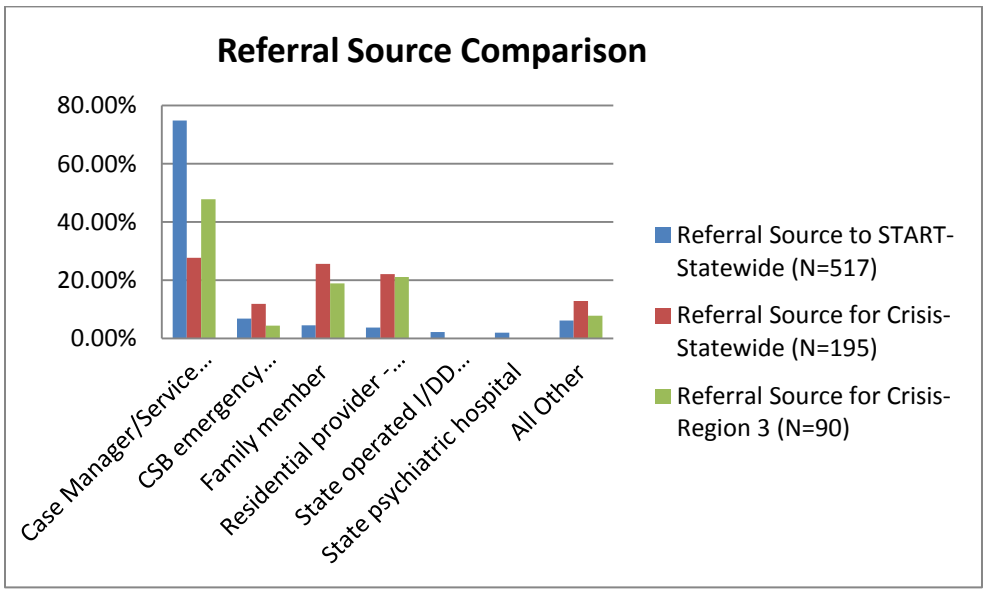
The following graph compares the most common presenting problems at referral to START statewide, referral to crisis services statewide, and referral to crisis services in region 3.



Referral Source

Following is the distribution of referral sources at the time of crisis contact. Since many individuals had multiple referrals to emergency services, this analysis looks at the total number of referrals statewide (N=195) rather than the unique individuals receiving services. Not surprisingly, case managers and service coordinators continue to be the primary sources of emergency referrals (28%). However, this is followed closely by family members (26%) and residential providers (22%), suggesting that there is growing awareness of the services within the community. It is also noteworthy that referrals to emergency services by case managers is much lower than referrals by case managers to START services overall (75%). For general START services, referrals from family members and community providers combined are just over 8%. This suggests that community awareness of the services available likely occurs first for emergency services. While these findings are similar in region 3, there continues to be a relatively high rate of referral by case managers (48%) in this region.

Source of Contacts/Referrals for Services	Number of Sources	Percent of Sources
Case Manager/Service Coordinator	54	27.69%
Community psychiatric inpatient	3	1.54%
Emergency services/Mobile crisis team	23	11.79%
Day/Vocational service provider - Community	5	2.56%
Family member	50	25.64%
Friend	1	0.51%
Hospital emergency department	2	1.03%
Law enforcement	0	0.00%
Legal advocate	0	0.00%
Residential provider - Community	43	22.05%
School	0	0.00%
Self	8	4.10%
State operated I/DD center	0	0.00%
State psychiatric hospital	0	0.00%
Other	0	0.00%
Not Reported	6	3.08%
Total	**195**	**100.00%**



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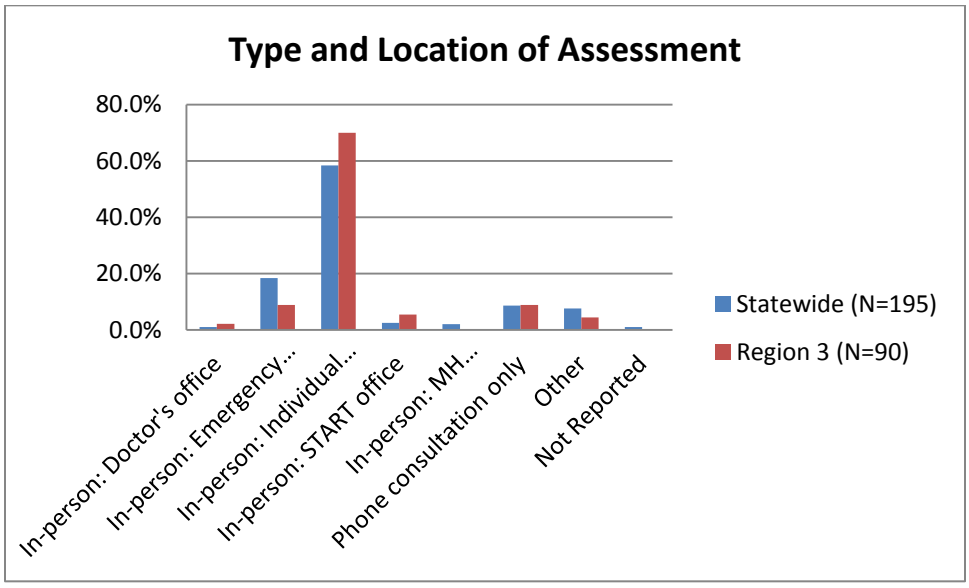
Emergency Assessment Types

The chart below shows the type and location of emergency assessments provided by the START team. Since assessments are conducted at each referral, the total referrals for this analysis are 195. About 58% of emergency assessments statewide were conducted in people's homes in person. This is consistent with the goal of mobile outreach support in during times of crises. In region 3 where services are more established, 70% of assessments take place in person in the home. It is important to note that 9% of the assistance was phone contact only. While teams are being encouraged to provide face-to-face assessments in order to develop relationships with community partners, families, and service users, the use of telephonic assessments will increase over time for known individuals and systems.

Type of emergency/crisis assessment	Number of individual emergency/crisis assessments	Percent of individuals with emergency/crisis assessments
In-person: Doctor's office	2	1.03%
In-person: Emergency room	36	18.46%
In-person: Individual residence	114	58.46%
In-person: START office	5	2.56%
In-person: MH outpatient clinic	4	2.05%
Phone consultation only	17	8.72%
Other	15	7.69%
Not Reported	2	1.03%
Total	**195**	**100.00%**



Case example

This vignette shows the importance of on-site emergency assessment in supporting all parties involved in supporting our START clients. Region V received a crisis call regarding "Jeff" at a local hospital. The caller (CM) informed START that Jeff was incoherent and had recently engaged in aggressive behaviors during a group home transition. During the assessment over the phone, it was determined that the Jeff was found to have high ammonia levels. Diagnoses provided included Autism, Mood Disorder NOS, Obsessive Compulsive Disorder, and Severe Intellectual Disability. Reportedly, Jeff had 11 medication changes over a four month period. While staff educated the caller regarding the significance of high ammonia levels, behavior, and Jeff's diagnoses, coordinators were dispatch to the hospital to provide crisis services. Education was provided to Jeff's family and providers at the hospital. An emergency respite placement was found and START provided daily face to face intervention until Jeff stabilized and his functioning returned to baseline. Daily follow-up continued, during which time staff were educated regarding Jeff's bio-psycho-social vulnerabilities, behaviors indicating possible difficulties, and potential triggers that may result in crises. A provisional crisis plan was developed and reviewed daily. Utilizing the team approach, Jeff obtained a comprehensive medical and psychiatric assessment. Jeff is currently transitioning into a permanent placement in the community with the assistance of START.

Another vignette demonstrates how in-home emergency assessment and support improve outcomes for START clients. LL is a 19-year-old, Caucasian female, diagnosed with Mild Intellectual Disability and Bipolar Disorder. She resides in a residential group home with five other residents. LL was initially referred to Region IV START in July of 2012 due to frequent (daily) episodes of severe agitation, property destruction, verbal aggression, suicidal ideations and elopement behavior that often resulted in psychiatric hospitalizations. Prior to engaging START, typical protocol for group home staff consisted of calling the police who would routinely transport LL to the nearest hospital. Since receipt of this referral, START has provided behavioral consultation and crisis supports to group home staff as well as education and collaboration with hospital staff when hospitalization was deemed necessary. Mobile Support Services have been an integral resource for providing group home staff with additional support and access of START Emergency Respite in Charlottesville has been utilized on one occasion. As a result, START's involvement has resulted in fewer admissions and improved transitions back into her home in the community. Since START began working with this individual and system it is noteworthy to highlight the number of hospital admissions has reduced significantly and she has not required any crisis interventions in over one month.

Reported Response Time following Emergency Request

It is essential that the START teams provide timely assessment and intervention services. It is important to note that this particular data was available for only 72% of the crisis referrals (N=140). In region 3 data are available on only 51% (N=46) of referrals. While this is a dramatic improvement from the last reporting period, one area of quality improvement will be the accurate and timely recording of all data points in SIRS. For those individuals with a response time reported, 73% (N=102) had a response time within the threshold of 2 hours. 27% (N=38) had a response time above the threshold. The program is still in development, but it is noteworthy that we are not on goal for a maximum two-hour response time at this point in service delivery. This issue is likely related to geographical obstacles in some regions and will need to be addressed.

Response time	Number of events by response time (N=140)	Percent of events by response time
Less than 2 hours	102	72.86%
2 hours or more	38	27.14%
Average response time	1 hour(s), 39 minute(s)	

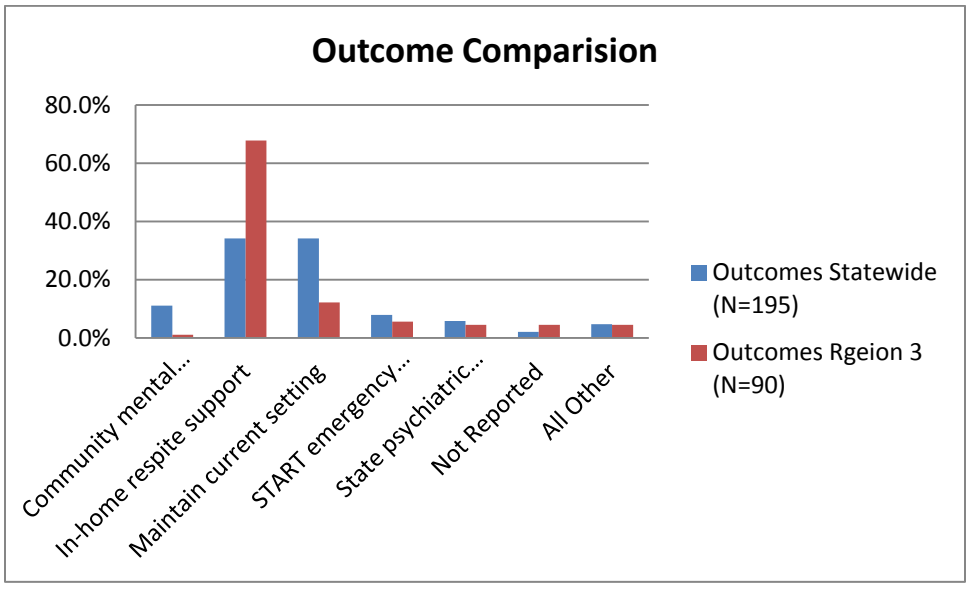
Virginia - Region 3		
Response time	**Number of events by response time (N=46)**	**Percent of events by response time**
Less than 2 hours	29	63.04%
2 hours or more	17	36.96%
Average response time	2 hour(s), 19 minute(s)	

Outcomes/ Primary Dispositions during Crisis Contact

The following table provides an overview of the outcomes associated with crisis contacts reported in SIRS. There is one primary outcome noted for each crisis contact, and there were nine contacts for which no outcome was reported. For 33% of individuals the outcome was in-home respite support provided by their regional START team. For an additional 33%, the recommendation was to return home without additional supports. There were 11 (6%) episodes that resulted in admission to state psychiatric facilities statewide and an additional 21 (11%) that resulted in a community mental health admission.

Final outcome/disposition of crisis contacts	Number of Outcomes	Percent of Total Outcomes
Community mental health in-patient unit admission	21	10.77%
Crisis stabilization unit/bed	1	0.51%
In-home respite support	65	33.33%
Maintain current setting	65	33.33%
Referral out for services	2	1.03%
START emergency respite admission	15	7.69%
START planned respite scheduled/provided	2	1.03%
State operated/private ICF/MR or other I/DD facility	1	0.51%
State psychiatric hospital admission	11	5.64%
Other	3	1.54%
Not Reported	9	4.62%
Total outcomes	**195**	**100.00%**

It is important to compare the statewide service outcomes to those in region 3 in which 68% of individuals were referred for in-home respite support and only 12% of individuals advised to maintain their current service setting. This suggests that as regions develop more experience and expertise, they are more likely to make recommendations that result in greater change and less frequent hospitalizations or community mental health admissions.



Case example

The following vignette demonstrates the impact of START crisis response on both short-term outcomes (such as inpatient admissions) and long-term outcomes for individuals and their families. This START client is a 22-year-old African American man with a broad history and wide variety of diagnoses. He was born with Spina Bifida, which affects his gait, and also has a diagnosis of Mild Intellectual Disability. This client experiences depression, psychosis NOS, as well as Post-Traumatic Stress Disorder. This client was referred to Region II START services by his local Community Services Board's Emergency Services therapist following two consecutive hospitalizations due to self-injurious behaviors (cutting and burning himself) and reported hearing voices and seeing people who aren't really there. Upon START intake, this client's school was his only other network of support outside of his maternal family (he resides with his maternal grandmother, aunt, and cousins).

When this client was a very young child, he witnessed the murder of his mother by her friend. That friend then committed suicide also in this client's presence. As a result, he and his sister were raised by their maternal grandmother. Upon START admission, it was disclosed that this client had been experiencing disruptive symptoms of PTSD, depression, and psychosis for many years, but did not want to worry those close to him, and therefore kept his experiences to himself. The voices and hallucinations were reportedly telling him to harm himself. He was also experiencing a lot of fear throughout the night and especially during thunderstorms.

This family has been feeling extremely stuck in not knowing how to proceed. This young man reportedly wants to make a productive and more independent life for himself, and his grandmother is extremely supportive of this him being able to eventually live more independently, though this client is unable to reside without supports and supervision. While receiving START services, this client and family have had access to the 24-hour crisis support line where mobile crisis support has been provided in order to help de-escalate this client from wanting to harm himself, as well as potentially harming others. He has been able to maintain his current residential setting without having to go to the hospital. He has also been able to access facility based respite to work on personal goals including positive socialization, feeling more independent, and coping with stress more effectively which has reduced his self-cutting and burning behaviors. This client has met with the START medical director and is receiving ongoing medication management through this support as well.

This START client has very realistic goals and dreams of one day being able to move out of his grandmother's home and into a group home setting, complete higher education and take some college classes, have a full-time job, and eventually be able to "open a center for children with disabilities to have positive social outlets and opportunities". Since working with START, this client has been able to identify short-term and long-term goals, and can begin seeing his dreams become a reality though our services and our ability to link this client and his family with additional supports and services of which they would not have otherwise known.

VA START Respite Services

The next sections provide a review of statewide respite service outcomes reported into SIRS for FY 13. It is important to note that all services are new and the utilization rates for all respite services are still

quite low. It is important to state that this summary is up until June 30th, 2013. As noted above however, respite services in Region 3 opened in December 2012 and are more than double those of utilization rates in the remainder of the state.

Emergency Therapeutic Respite

VA START Emergency or Crisis respite was provided to a total of 28 (5.4%) individuals in this reporting period. Half the individuals served were from Region 3 (N=14) which has an emergency respite utilization rate of 12.3%. The average length of stay both statewide and in Region 3 is 18 days

While it is still too early to detect trends in the data, it is interesting to note that Region 3 has a much lower recidivism rate for emergency respite than the statewide rate. One possible explanation is that in Region 3, 40% of emergency respite users have a cross system crisis plan compared with fewer than 17% statewide. As other regions become more experienced in the development of effective crisis planning the recidivism rate may decrease for this service. Note that the presence of a cross system crisis plan is evaluated at each respite episode, so the denominator is the number of respite stays rather than the number of individuals. The recidivism rate for emergency admissions in region 3 is on target with the goals of the program. Their compliance with the therapeutic model has been outstanding and may account for the better outcomes.

Statewide

Number of individuals admitted to Emergency Respite	28
Number of Emergency Respite Admissions	36
Average Length of Stay	18.8 days
Recidivism	28.6%
Maximum	2 admissions

Region 3

Number of individuals admitted to Emergency Respite	14
Number of Emergency Respite Admissions	15
Average Length of Stay	18.2 days
Recidivism	7.1%
Maximum	2 admissions

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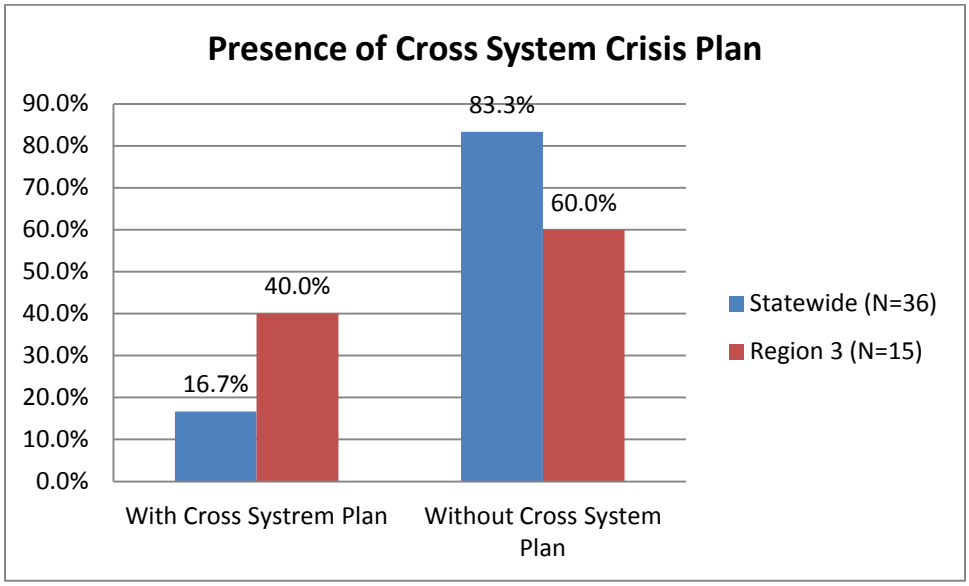
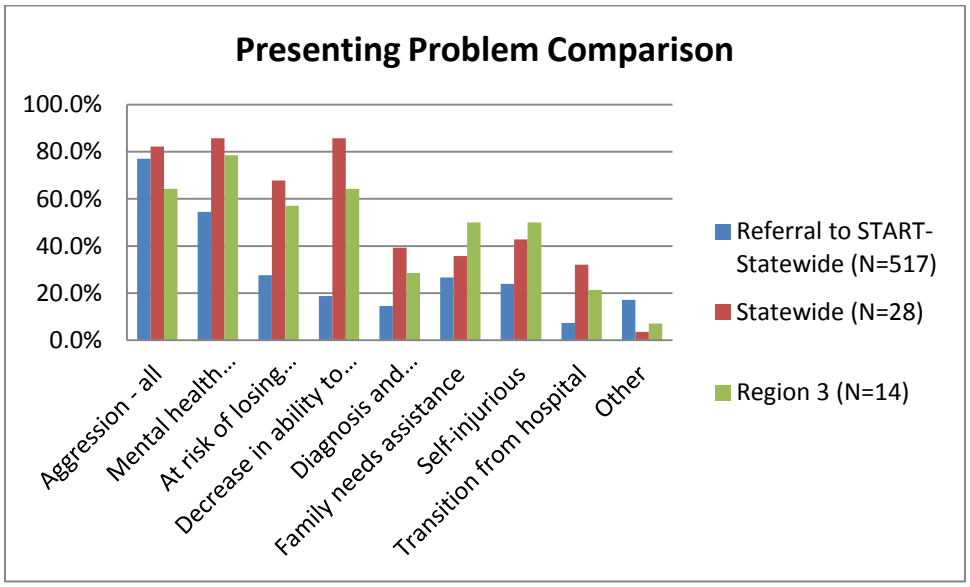


Presenting Problem

Below is a description of the reasons expressed for emergency respite admissions for the 28 individuals statewide. While aggression remains a major factor in emergency respite admissions (82%), it is actually slightly lower than concerns about mental health symptoms (86%) and a decreased in ability to function (86%). As seen overall, most individuals report multiple issues (4.8) at admission to emergency respite.

In Region 3 there is a higher incidence of individuals reporting family concerns (50%) and self-injurious behavior (50%) than is seen statewide. This may be an indication that emergency respite is being used slightly more proactively in this region.

Presenting problems at time of referral to emergency respite	Number of Individuals Reporting Problems	Percent of Individuals Reporting Problems
Aggression - all	23	82.14%
Mental health symptoms - all	24	85.71%
At risk of losing placement	19	67.86%
Decrease in ability to participate in daily functions	24	85.71%
Diagnosis and treatment plan assistance	11	39.29%
Family needs assistance	10	35.71%
Self-injurious	12	42.86%
Transition from hospital	9	32.14%
Other	1	3.57%
Total Emergency Respite Recipients	**28**	
Total presenting problems	133	
Average # of Problems Reported	4.8	



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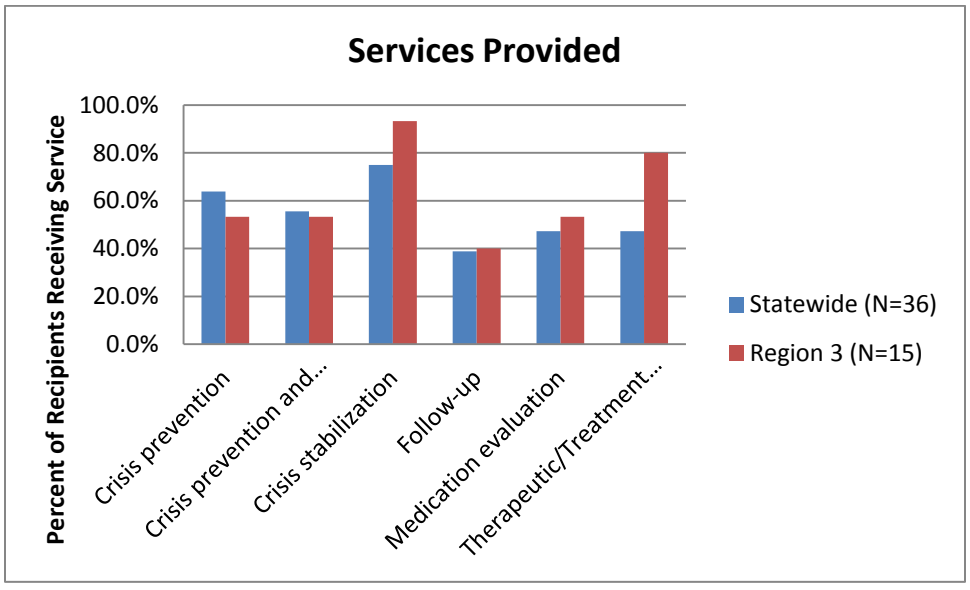
Services Provided

While crisis stabilization and prevention are primary goals of emergency respite services, START teams are also trained to provide evaluation and treatment planning services to help prevent future emergency services. Statewide, 47% of emergency respite recipients were provided with these services. In region 3 there were similar rates of crisis stabilization and prevention, but there was a 33% increase in the percent of individuals receiving assistance with therapeutic/treatment planning. Like the presence of crisis plans, this more comprehensive approach to planning may contribute to the lower recidivism rate of Region 3 emergency respite users. **Note: Fidelity to the model requires that all START respite admissions include crisis prevention and intervention plans.**

Services provided while utilizing Emergency Respite	Number of individuals utilizing the service	Percent of individuals utilizing the service
Crisis prevention	23	63.89%
Crisis prevention and intervention planning	20	55.56%
Crisis stabilization	27	75.00%
Follow-up	14	38.89%
Medication evaluation	17	47.22%
Therapeutic/Treatment planning	17	47.22%
Total Emergency Respite Recipients	**36**	



The following vignette exemplifies how emergency respite can be key in developing a clear understanding of our clients and lead to improved outcomes for them and their support teams.

Tammy is a woman living with Autism and obsessive compulsive disorder and was referred to the Region I START program by her case manager and group home provider. They were seeking support in figuring out what was happening to Tammy. During the initial meeting with the team, they expressed how she had progressively declined in her ability to take care of herself. She had significant periods of agitation that were expressed in loud screaming and violent outbursts. She wasn't sleeping well. The team had sought psychiatric care and the medication adjustments didn't appear to be working.

It was determined that Tammy should come to the START respite home on an emergent basis for medication review and to attempt to understand the nature of the changes in her behavior noticed by the team. A meeting was set up prior to admission with her case manager, day program, and group home staff. The respite team proceeded to glean the information concerning her routines and needs so that the transition to respite would be as smooth as possible. The team was excited to provide their wealth of knowledge concerning Tammy. The transition to respite was fairly smooth and weekly discharge planning meetings were well attended by her team. The team members were very interested in Tammy's progress at respite and provided good insight into the changes that were being seen. Through medication adjustment and interventions to provide clear structure for her day, Tammy showed many positive improvements during her stay. Aggressive tendencies decreased and she was able to sleep in a more typical pattern. Her speech became clearer and she was able to perform ADL tasks more effectively. The team was pleased at the end of her respite stay to find that Tammy much more closely resembled the person that they knew her to be in the past. The team continues to work with Tammy in the same home setting and have expressed their satisfaction with the service received.

Planned Therapeutic Respite

Planned therapeutic respite services are designed to support families and those who provide unpaid natural supports to individuals who are eligible for START services. This important service requires outreach and support to assist families in accessing therapeutic respite. It helps prevent crisis service use and helps families remain together. It is a service that takes time for people to be aware of and feel confident in the provider to assist a loved one. To date 31 (6%) START service recipients have used planned therapeutic respite according to the data reported in SIRS. Half of these services were provided in Region 3. The length of stay ranged from 2 to 5 days, which is right on target.

As with emergency respite services, individuals receiving planned respite in Region 3 are more likely to have a cross system crisis plan, which may contribute to the lower recidivism rate.

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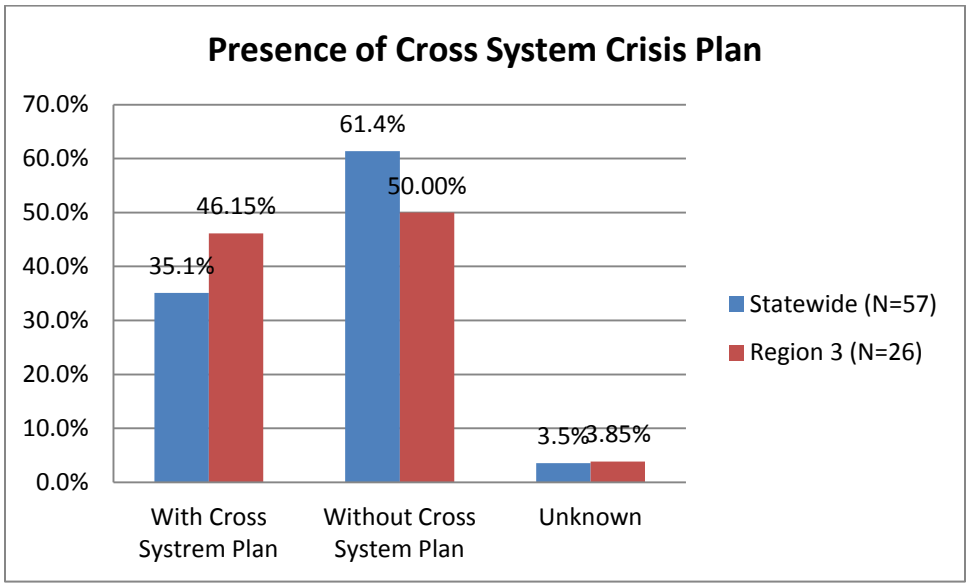
Statewide

Number of individuals admitted to Planned Respite	31
Number of Planned Respite Admissions	57
Total number with more than one admission	16
Average number of admissions per individual	1.8
Average Length of Stay	4.6 days
Recidivism	51.6%

Region 3

Number of individuals referred for Emergency Respite	15
Number of Emergency Respite Episodes	26
Average Length of Stay	3.1 days
Recidivism	33.3%

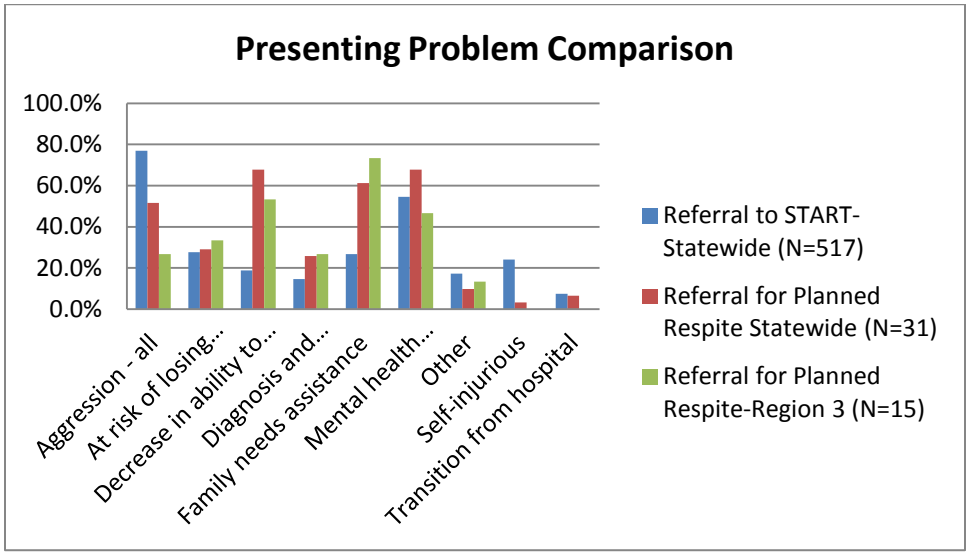


Presenting Problem

Below is a description of the reasons expressed for planned respite admissions for the 31 individuals statewide. As in emergency respite services, concerns about mental health symptoms (68%) and a decreased in ability to function (68%) as well as family needs assistance (61%), slightly outpace concerns about aggression (52%).

In Region 3, family needs assistance is the most frequently cited referral reason (73%), which suggests that more families are familiar with and willing to use planned respite services.

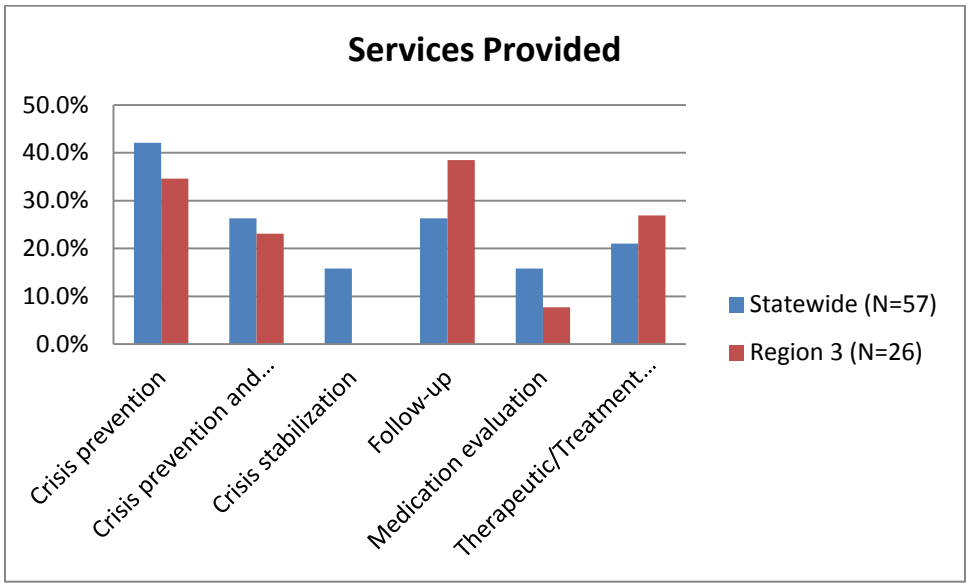
Presenting problems at time of referral to planned respite	Number of Individuals Reporting Problems	Percent of Individuals Reporting Problems
Aggression - all	16	52%
Mental health symptoms - all	21	68%
At risk of losing placement	9	29%
Decrease in ability to participate in daily functions	21	68%
Diagnosis and treatment plan assistance	8	26%
Family needs assistance	19	61%
Self-injurious	1	3%
Transition from hospital	2	6%
Other	3	10%
Total Planned Respite Recipients	**31**	
Total presenting problems	100	
Average # of Problems Reported	3.6	



Services Provided

It is important to note that "planned respite" is provided to high-risk individuals only, and therefore is part of the crisis response continuum. As a result, planned respite focuses on the individuals with the fewest ongoing paid resources and those who require follow-up and assessment services in the context of their vulnerabilities. Crisis prevention continues to be a primary service provided to planned respite recipients (42%). There is a much lower rate of crisis stabilization offered statewide (16%) and no crisis stabilization services were provided in Region 3. This is a positive outcome, since this service is designed to prevent rather than mitigate crises.

Services provided while utilizing START planned respite services	Number of individuals utilizing the service	Percent of individuals utilizing the service
Crisis prevention	24	42.11%
Crisis prevention and intervention planning	15	26.32%
Crisis stabilization	9	15.79%
Follow-up	15	26.32%
Medication evaluation	9	15.79%
Therapeutic/Treatment planning	12	21.05%
Total Planned Respite Recipients	**57**	



In-Home Therapeutic Respite

Since two out of the five regional centers (respite homes) were not yet operational, in-Home respite services were the most widely used of the respite services available through VA START. These services have been implemented in all but region 5, and often families are more comfortable beginning services in a familiar environment rather than one that is facility based. Statewide, 62 (12%) of all START recipients have accessed this service. As with the other services, over half the recipients are from Region 3 (N=35). Unlike other respite services, in-home supports are designed for both emergency assistance and to be ongoing and prevent the need for future more intensive services; thus, a high recidivism rate is a positive outcome in some cases.

The following is a brief look at utilization rates for In-Home respite as well as the services provided. Data on the presenting problems at time of referral are not available for this service.

Statewide

Number of individuals referred for In-Home Respite	62
Number of In-Home Respite Episodes	222
Average Number of Hours	15.9 hours
Recidivism	50.0%

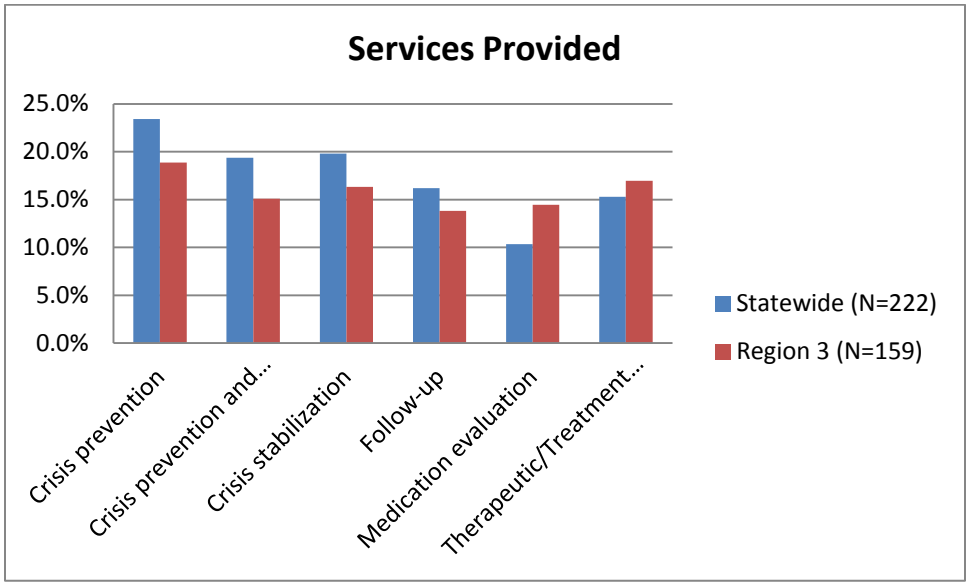
Region 3

Number of individuals referred for In-Home Respite	35
Number of In-Home Respite Episodes	159
Average Number of Hours	21.1 hours
Recidivism	60.0%

Services Provided

The tables below describe services provided through in-home therapeutic respite. This is also referred to crisis stabilization in-home supports in the DOJ settlement agreement. Services provided through In-Home respite are designed to be highly individualized, so there is a fairly even distribution among all the services and no marked differences between the statewide services and those in Region 3.

Services provided while utilizing START In-Home respite services	Number of individuals utilizing the service	Percent of individuals utilizing the service
Crisis prevention	52	23.42%
Crisis prevention and intervention planning	43	19.37%
Crisis stabilization	44	19.82%
Follow-up	36	16.22%
Medication evaluation	23	10.36%
Therapeutic/Treatment planning	34	15.32%
Total In-Home Respite Recipients	**222**	

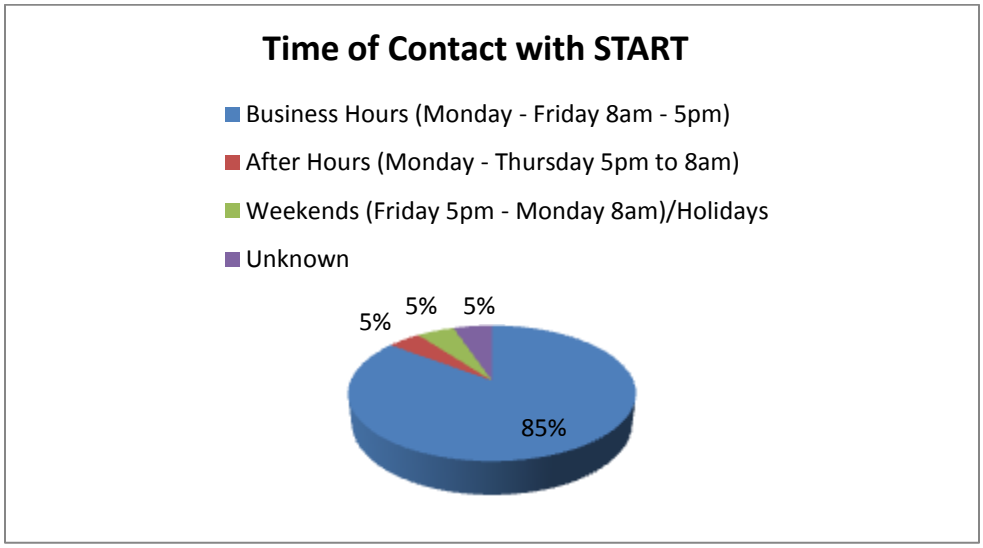


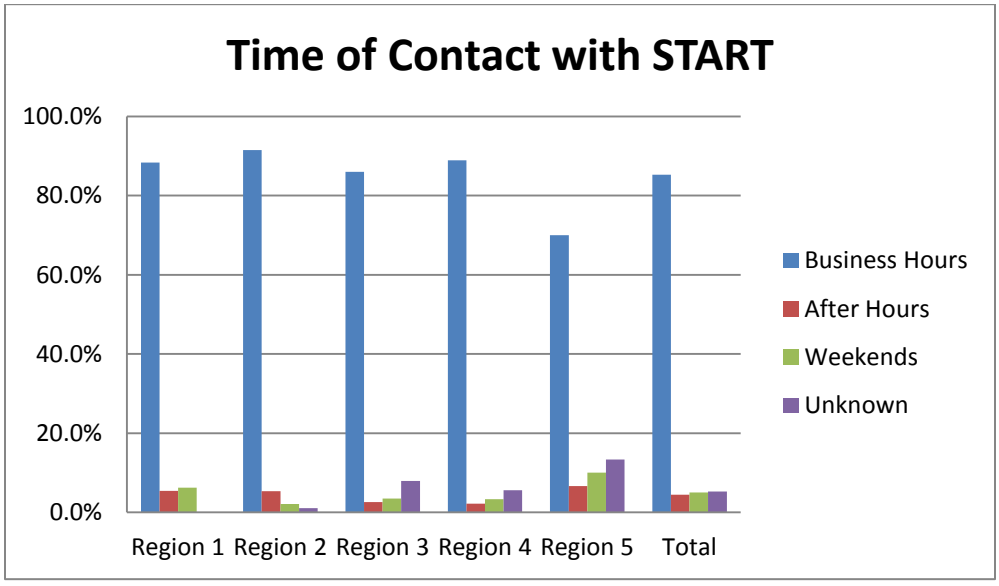
Additional START Clinical Team Services

This section of the report will review information gathered to date about START clinical services. It should be noted that this is a very new program so that the data reported only reflect a snapshot of a brief period of time and cannot be considered a trend in terms of long-term service outcomes.

When Services are provided

The vast majority of VA START services statewide have been provided during business hours (85%). As services are rolled out across the state, we expect to see an increase in the percent of services provided on weekends and after hours. There are no marked regional differences in time of contact.





Case Load

There is a wide variation in caseload size across the state with an average of 13 individuals per coordinator in Region 2 to almost 26 in Region 1. The statewide average is over 17. As regions are able to hire and train additional coordinators it is hoped that the average caseload size will stabilize at around 25. It is important to note that since all of the individuals coming into the system are new referrals, the early implementation phase of the program results in high time intensity per individual START recipient as they all require intakes, assessments, and cross systems crisis prevention and

intervention plans. Once well underway, each Coordinator will be expected to carry an average caseload of 25 individuals with various levels of need as indicated in their START plans.

Caseload Distribution						
	Region 1	Region 2	Region 3	Region 4	Region 5	Statewide
Current number of START Coordinators	5	7	7	5	5	29
Number of Individuals	129	94	114	90	90	517
Average Caseload	25.8	13.4	16.3	18	18	17.8

START Specific Assessments and Training Provided

The table below provides the number of START clinical team Cross Systems Crisis Prevention and Intervention Plans (CSP), Comprehensive Service Evaluations (CSE), and Clinical Education Team reviews (CET) provided by each region. All are core elements of service delivery for each program. It is expected that the vast majority of the individuals supported will have CSPs, while only about 20% will have CSEs.

CET regional trainings are forums required to occur monthly. The reporting indicated that the implementation of these important services has been sporadic with regard to statewide trends so far. Some of this can be explained by the differing stages of development. All START services are being taught to the teams and therefore productivity is expected to lag somewhat. In addition, Regions 3 and 5 were not expected to begin their CETs until later in the fiscal year, so it is expected that they will be provided by the next reporting period. Region 2 did not have a license for much of the reporting period but was able to provide CETs. This may help to explain their numbers. Each region must have a minimum number of CSEs, CETs, and CSPs completed in order for their coordinators to be proficient enough at each to be certified. The numbers may indicate that certification will take longer to achieve than was expected in some regions. *At the time of this writing, certification has occurred for several coordinators in region 3 (Director, Team Leader and one START Coordinator) and in Region 2 two START Coordinators have been certified with one provisional certification. Additional certification reviews have been scheduled for staff in regions 2, 3, and 4. As of August 2013, there are certified personnel in regions 1, 2 and 3. Certification should allow for increased numbers of assessments and training provided because those who are certified do not require signature of their Clinical Director.*

The development of Cross Systems Crisis Prevention and Intervention Plans takes about 30 days to complete after the team has agreed to work together in a joint effort to develop a clear strategy. Since this process is new in Virginia, it has taken a bit longer to accomplish, and provisional plans are used as a way to engage the system in working together while the team learns to collaborate more effectively. Each time this is accomplished, the members of the team become more willing and able to collaborate in the development of effective plans. This is an important process intended to improve the competence of the system as a whole. Dr. Weigle has been working with teams to review their CSPs, and we have had several trainings and workshops. The teams are improving in their skills. It is expected that the CSP

process will improve over time and the time it takes to develop the plans will be more in line with the 30 days it takes in other states.

Region 4 had difficulties reporting these numbers in the SIRS so that we cannot accurately report them at this time. (See addendum with regional summaries for more information). In addition, the earlier version of the SIRS did not have a place to enter provisional crisis plans. We are changing this to better document the process. Individuals with provisional plans should have a completed plan within the next 30 days. We requested this information from all regions and received it from Regions 2 and 3. Regions 2 and 3 data indicate that this is not yet occurring. Again, the beginner level of proficiency of new staff lengthens the process. It is expected that there will be a much greater number of completed CSPs in the next fiscal year. It is important to note that as was reported in both regions 2 and 3, the crisis planning process is central to service delivery.

Number of CSPs, CSEs, and CET forums Completed by Region

	# Full CSPs	# CSE	# CET Forums	# Provisional CSPS
Region 1	5	7	6	126
Region 2	35	12	5	109
Region 3	43	38	2	133
Region 4	31	3	0	92
Region 5	54	3	0	90
Statewide	168	63	13	550

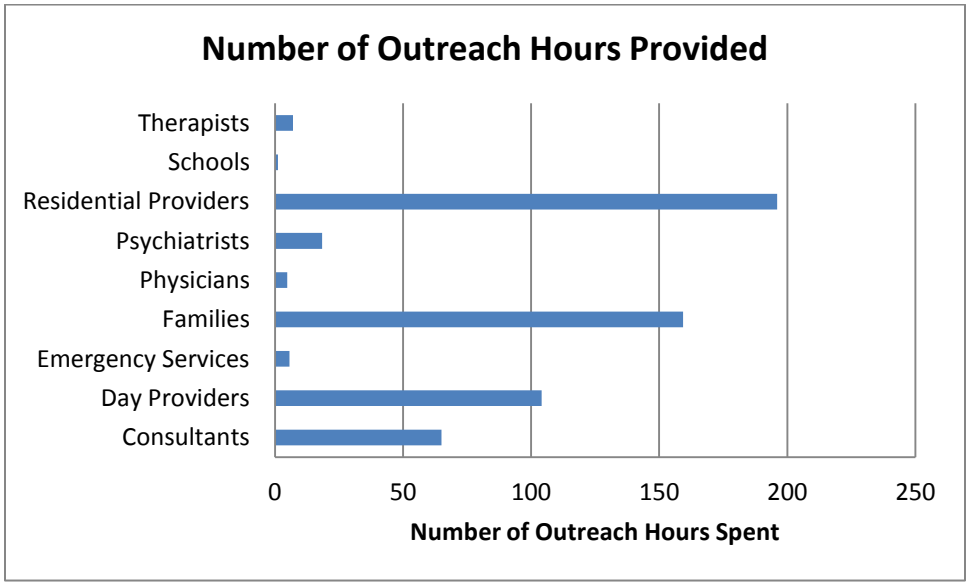
In addition to the services listed above, START recipients receive a variety of assessments provided by coordinators. These include the Aberrant Behavior Checklist (ABC) and the MEDS. For both of these, assessments can be administered at intake, follow-up services, and at a crisis referral, so some individuals may have multiple administrations. The MEDS is only conducted at center-based respite. This explains the lack of MEDS from regions 4 and 5 since they do not yet offer this service.

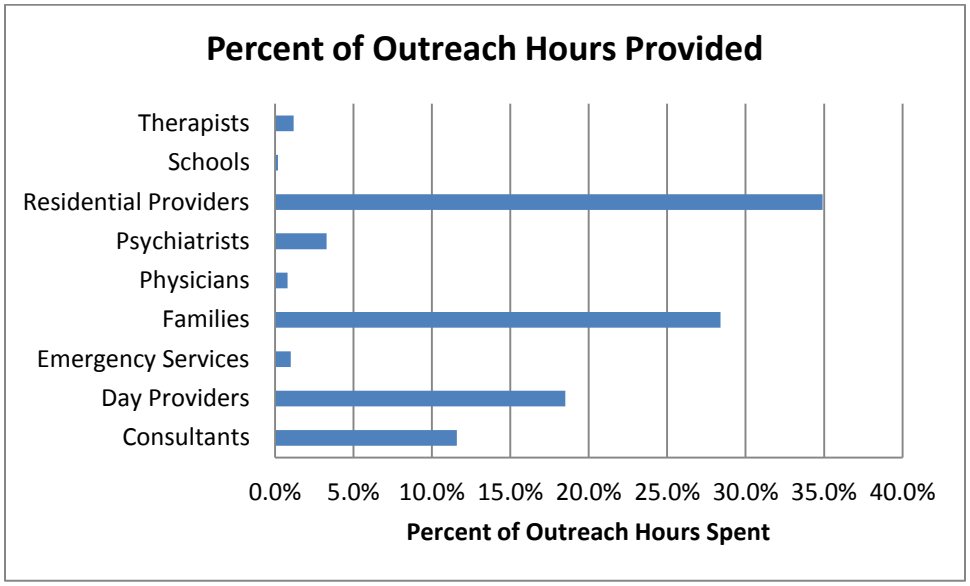
	Number of Individuals	Number of ABC's Completed
Region 1	30	38
Region 2	25	26
Region 3	32	32
Region 4	39	50
Region 5	54	74
Statewide	180	220

	Number of Individuals	Number of MEDS Completed
Region 1	22	40
Region 2	21	67
Region 3	35	116
Region 4	0	0
Region 5	0	0
Statewide	78	223

Outreach Services

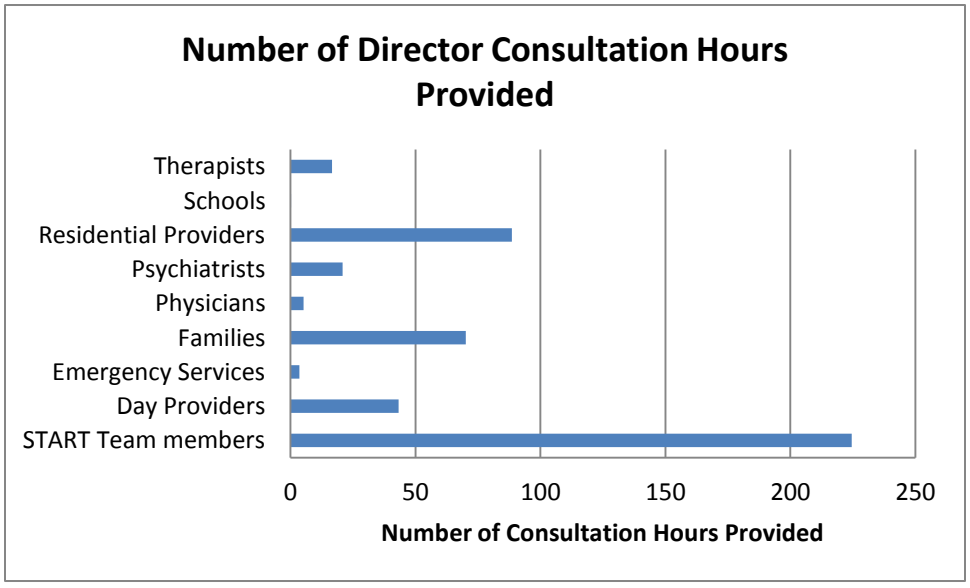
The graphs below present both the number and percent of hours providing outreach services as reported in SIRS by START Clinical Teams. The data indicates that the majority of outreach time is being spent with residential and day providers and family members.

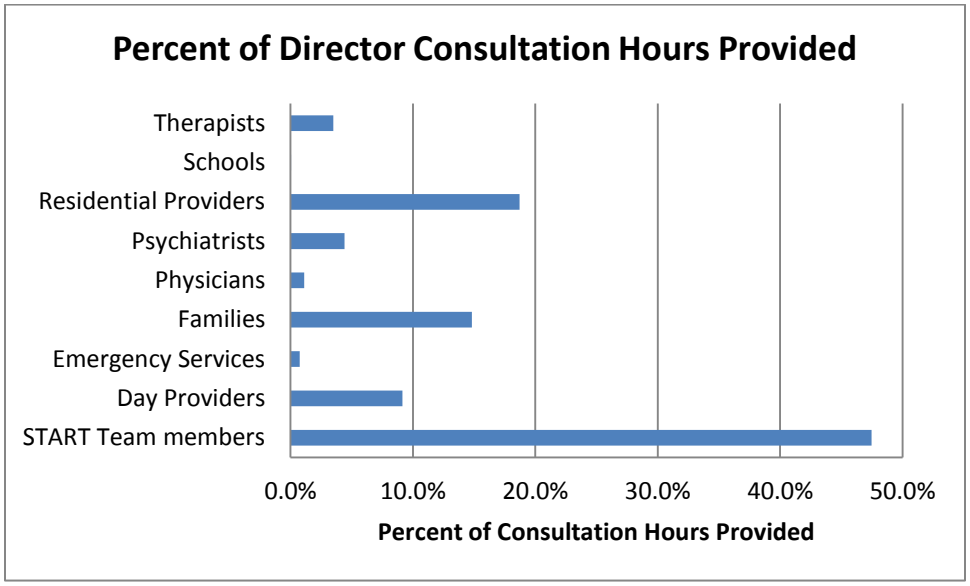




Consultation Meetings Provided by Clinical and Medical Directors

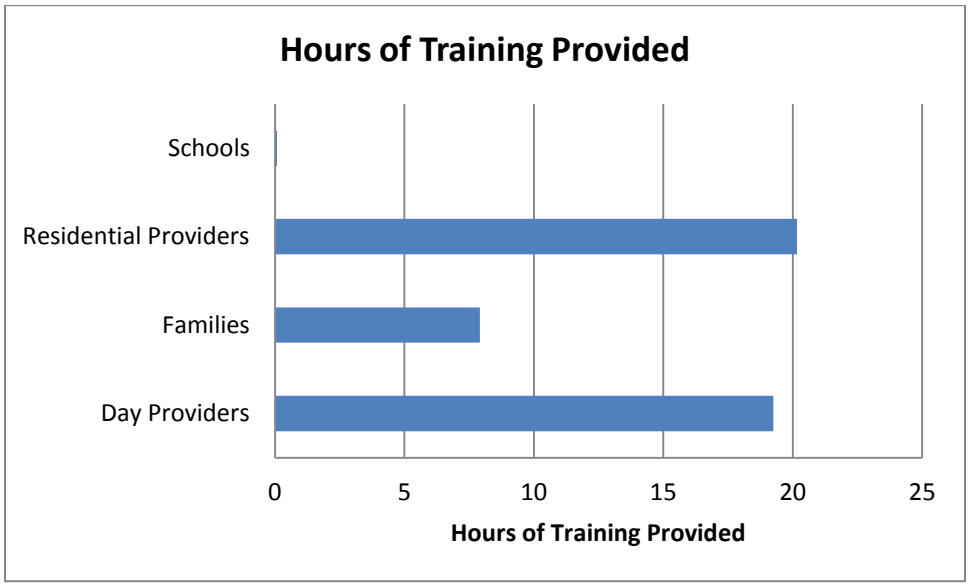
Below is a similar look at the number and percent of consultation hours provided by the Clinical and Medical Directors. Since the program is still very much in the start-up phase, it is not surprising that the majority of consultation time is spent with START staff (48%). Time spent with families (15%) and residential providers (19%) make up the majority of the remaining consultation time.





Training provided with regard to START services and supports

Below is the reported time spent training members of the community system about START services. The majority of trainings have been provided to residential and day providers. More training is an integral part of the START model and topical trainings and will be reported in future summaries as they occur.



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Affiliation and Linkage Agreements

Affiliation and linkage agreements are keys to successful implementation of START services. There are expressed concerns about service and resource provision, access to appropriate inpatient care, and the ability to consistently collaborate with case managers, mental health emergency service teams, residential providers, and day program providers. It is essential that affiliation and linkage agreements be developed to clearly define roles and responsibilities in these and other important contexts as we move ahead. There is a concern about the low number of agreements statewide. As would be expected, Region 3, the most mature of the programs to date, has 38% of the linkages statewide.

Following is the information reported by Regions with regard to linkage agreements they have obtained to date:

	Number of Affiliations/Linkage Agreements
Region 1	4
Region 2	7
Region 3	10
Region 4	5
Region 5	0
Statewide	26

START Training Descriptions

The Center for START Services at UNH provides ongoing training by experts in the field to VA START staff and their community partners. Many of the training topics offered can be shared with community partners based on interest. The trainings are recorded so they can be viewed repeatedly and at the convenience of viewers. Following is a description of training topics offered.

START Overview

The START Coordinator certification process begins with an in-depth overview of the START model, its essential components, and current applications across the United States.

Systemic Consultation Seminar

Comprehensive service evaluations provide an in-depth overview of an individual's services to strengthen service outcomes for individuals with intellectual/developmental disabilities and their families in the community.

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START Coordinators learn effective strategies and protocols for conducting comprehensive service evaluations. Coordinators learn how to conduct a comprehensive record review, develop and present evaluation reports and findings, and how to provide additional consultation as needed.

Introduction to Mental Health Aspects of Intellectual Disability

People with intellectual and developmental disability (I/DD) can experience the full range of mental health problems. Yet, they are often under-diagnosed and misdiagnosed due to the lack of understanding of their disability. As a result, people with ID do not receive the appropriate treatment and supports. Therefore, it is imperative that we understand the mental health aspects of ID, so that we can help them have the best possible quality of life in the community.

START Coordinators are taught to understand difficulties in the diagnosis of mental health conditions in people with ID. They become familiar with the most important mental health conditions by learning about those psychiatric disorders and treatment.

Participants understand specific clinical presentations as well as treatment and support adaptations for mental health problems in people with ID. As a result, START Coordinators will be knowledgeable and confident in advocating for and supporting individuals served by START programs.

Seminar in Practice Applications for Systemic Consultation

START Coordinators practice lessons learned in the Systemic Consultation course by conducting comprehensive service evaluations through live supervision and mentoring.

Outreach & Working with Families

Cross systems collaboration and working with families are two essential components to improving service outcomes for individuals with intellectual / developmental disabilities and their families. Coordinators receive training in techniques to be effective agents of change and participate in live supervision to hone these skills.

Cross Systems Crisis Prevention & Intervention

Cross Systems Crisis Prevention & Intervention training prepares coordinators to develop an individualized, person-specific written plan of response that provides a specific, clear, concrete, and realistic set of supportive interventions that prevents, de-escalates and protects clients experiencing a mental health or behavioral health crisis. Complimentary components include:

- Interactive training on crisis evaluations
- Live peer-review session

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Positive Behavior Supports

Understanding the philosophy of Positive Behavior Supports (PBS) and how to develop an appropriate plan is key to a START Coordinators role. This course provides an overview of PBS and the vital elements required for a successful plan.

Project-Specific Trainings

· START Respite Admission/Discharge Summary Overview (only for START programs that provide respite)

· START Crisis Evaluations

· START Data Tracking, Collection/ Monitoring

· START Quarterly/Annual Report/ Data Analysis

Workshops

· Live supervision tape review for respite

· Peer review CSCPs

· Peer review of CSEs

· Systemic analysis reviews

· Peer review and Admission/Discharge summaries writing workshop

· Technical support for report writing

· Attendance at Advisory Council meeting for annual reviews

National Online Training Series

The National Online Training Series on Mental Health and Intellectual Disability provides Coordinators with enhanced research-based trainings led by experts from across North America. The series also offers two online Team Meetings to bring together all active START projects for information sharing among colleagues. The 2012-2013 series included:

Summer 2012: Physicians & Clinicians Series, Four-Part Series Presenter: Jarrett Barnhill, MD, University of North Carolina Chapel Hill, Department of Psychiatry, Neurosciences Hospital

January 11, 2013 - Multi-Modal Assessment/Treatment of Aggression Presenter: Dr. William Gardner, Professor Emeritus, University of Wisconsin-Madison

March 8, 2013 – Attention-Deficit/Hyperactivity Disorder (ADHD) in ID Presenter: Anne Desnoyers

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Hurley, Ph.D. Research Associate Professor, Institute on Disability - University of New Hampshire & Tufts University School of Medicine

April 12, 2013 - Effective Dialog Between Physicians & Primary Care Givers Presenter: Nabih Ramadan, MD, MBA, Chief Medical Officer, Medical Administrator, Nebraska Department of Health and Human Services, Division of Developmental Disabilities

May 10, 2013 – Integrated Assessment of Behavioral Problems: Collaborating to Develop a Common Language Presenter: Dan Baker, Ph.D., Associate Professor of Pediatrics, The Elizabeth M. Boggs Center, Robert Wood Johnson Medical School

Registrants by region for the annual START Online Training Series on Mental Health & IDD are as follows:

Region	# of Registrants (START Staff & START Center Staff)
1	14
2	14
3	28
4	22
5	11
Other (e.g., state staff)	6

Conclusion/Recommendations

This report summarizes and analyses data entered in the SIRS for the implementation of VA START during fiscal year 2013, the first full year of VASTART implementation. The Regions have provided separate analyses (see addendum). Note that these individual region reports may contain more information than in the SIRS. Region 4 in particular appeared to not enter data into the SIRS this year, and has provided data in their report that is more comprehensive as a result. The individual region reports will provide greater data from within each region of the state, along with individual goals and objectives for the coming year in response to specific region-wide needs.

We have used Region 3 to "pilot" a full year of programming for this analysis. Virginia START appears to be very successful in Region 3. Regions 1, 2, and 3 are now fully operational and have exhibited fidelity to the model. It is expected that in the coming year, Regions 1, 2, and 3 will continue to move ahead in the process. Regions 4 and 5 continue to have difficulty with full implementation of the model but at the time of this report, Region 4 has a concrete plan of action to improve services and outcomes. Region 5 will be working toward this goal as well. (See Regional summaries.)

This endeavor is a systems change model and VA START is not the only system being developed in response to changes in the state system. As a result, there have been a number of challenges in moving ahead. The goal is to develop a proactive and preventative system of support to allow for a community safety net to be in place for those in need but to also prevent the need for that safety net whenever

possible. In order for this to occur, the continuum of supports and services must be in place and START must play an active role in the process.

Concerns about Mobile Emergency response

While the consistent application of policies and procedures in the context of the START model throughout the state of Virginia has many benefits, some issues will require more local adaptation of the model. One important service is Emergency response. In some areas within regions of the state, there is ability for the MH Emergency team to be mobile and actively collaborate with START coordinators. However in other areas of the state, there is no MH mobile crisis capacity. Each region must come up with a plan within its existing system with the support and guidance of the state. A timely, effective mobile response is needed in all regions. The START model requires that whatever is decided, it improves the capacity of the entire system to support the population. We do not promote the designated of an IDD team that stands alone. However, the VA START programs take a primary role in both providing supports and proposing remedies as needed. Our recommendation to all START teams in Virginia is to do what works to help with mobile capacity, to respond as needed and to insure safety and effective support takes place. In less mature systems, this means that the START team may have to do more initially. This should be determined locally keeping in mind that the entire system needs to improve their capacity to support the population. Whatever is decided, it will require systematic ongoing review and dialogue between partners to promote improvements over time.

Following are recommendations for the coming year for the State and the Regions to consider:

1. A plan is needed to articulate response times, services and resources within each region of the state with all parties participating, including day and residential providers who have some role in the development of an appropriate response.
2. Address gaps in the system with regard to behavioral health care. There are several gaps in the system. These include the lack of access to inpatient care for those who could benefit but also the lack of services for those who are too disabled and/or medically fragile to benefit from traditional inpatient mental health care. While more than 50% of the population is higher functioning, there are a significant number of START service recipients who would not be successfully served at traditional mental health inpatient facilities. It is recommended that the state consider the development of a specialty inpatient service that can work with VASTART to fill in that gap. While the goal is to prevent the need for these services, they will in fact sometimes be needed. (see Attachment 1)
3. There should be a greater focus on training day program and residential providers who serve the dually-diagnosed population and to provide ongoing consultation and support to these providers through the START teams moving forward.
4. There continues to be disparity between regions with regard to fidelity to the START model. We ask for increased support around this issue.
5. There needs to be clarification statewide about the role of case managers working the START Coordinators. The program relies heavily upon active and ongoing collaboration.
6. There needs to be revisions of the SIRS to better capture the needed information. Linda Bimbo is working with Bob Villa and the START Directors to insure this takes place.
7. Response time in emergencies needs to be reviewed. This was not consistently reported by regions in the SIRS and is of great concern going forward. Response time in crisis is key for the

system to be engaged and for the programs to be effective. The barriers to reasonable response times should be reviewed and considered. First and foremost however, response time must be consistently reported so that we can better address the challenges.

8. We have again attached the satisfaction survey. We suggest implementing the process as soon as possible. (see attachments 2 and 3)
9. There also needs to be a satisfaction survey for respite services.
10. We strongly recommend the development of a therapeutic respite advisory group made up of families, guests, and some other stakeholders of your choosing.
11. We would like to work with licensing and QA service to insure that START programs comply with licensing, and that licensing promotes the fidelity of the START programs.
12. Each region should target the number of staff they expect to have certified in this last scheduled training year.
13. CETs are not being provided nor are trainings being conducted at the rate that was hoped. We ask that this be a goal in the coming year.

We want to take this opportunity to thank everyone involved in this complex and rewarding project. We look forward to continuing to improve outcomes and services in the year to come.

Submitted by,
Joan B. Beasley, Ph.D.
Director, Center for START Services

Karen Weigle, Ph.D.
Director of Training and Certification
Center for START Services

Editors: Linda Bimbo, Ann Klein, Julie Moser

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Addenda

Attachment 1: Comparative analysis between START respite, Residential services, and inpatient care

Attachment 2: Stakeholder Survey

Attachment 3: Care recipient survey

Attachments 4-8: Regional summaries

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Attachment 1: Comparative analysis of community settings

Setting/services	Residential (non ICF)	Typical Community In patient psychiatric hospital	START Center
Criteria	Must meet eligibility criteria and be able to benefit from program, including setting, staffing and services. Must be able to be safely supported in the setting. Can support very severely impaired individuals based on the program design Requires collaboration with other providers and treaters Goals are established through service planning and can take several months to achieve.	Must have an acute mental health condition that can benefit from a brief stay. Must leave when ready for discharge, can be transitioned through START Center when needed. Must be manageable on a traditional mental health unit. This often requires START assistance. Goals for assessment and treatment must be established upon admission. Typical MH units are not designed for persons with severe/profound impairment	Must meet the criteria for START services and have a place to return to upon discharge. Must have active collaboration with providers and treaters to assist the individual and the system of support. Goals for assessment and treatment must be established upon admission Designed for individual ranging from mildly IDD to profoundly IDD. Can meet a range of criteria. Do not have to be diagnosed with ID or MI to be admitted.
Locked	No	Yes	No
Long term care	Yes	No (brief care usually 7-10 days)	No (up to 30 days)
Planned admissions	Yes	No	Yes (up to 5 days)
Acute care admissions	Not typical	Yes usually through ER	Yes, requires medical clearance

Voluntary only	Yes	No	Yes
Service recipient is known as	Resident /client	Patient	Guest
Independent community access	Yes	No	No
Ongoing collaboration with community treaters, family, etc	Yes	In general No, in an ideal situation yes.	Yes
Single bedrooms	Sometimes	Sometimes	Yes
Access to household items, sharps	Yes	No	Supervised and limited only
Community activities	Yes	No	Yes
Access to snacks and food outside of planned menu	Yes	No	Limited
Television, personal cell phone, electronic devises	Yes	limited	No
Therapeutic structure	No	Yes	Yes
Crisis supports in house	limited	Yes	Yes

Mechanical and chemical restraint options	No	Yes	No
Management of aggression and acute conditions	No	Yes	Yes
Management of chronic medical conditions	When designed to do so	Yes	With additional supports
Treatment/service plan required	Yes	Yes	Yes
Access to bed and bedroom during the day	limited	limited	No (unless prescribed by MD)
Day program provided	NO	Treatment groups	Yes, therapeutic day
Supervision required	variable	Line of sight atypical 30 minute checks	Line of sight with night checks
Setting designed to support people with autism	When designed to do so	No	Yes, low sensory room, sensory integration
Caregiver training provided	Somewhat	Not typical	Ongoing
Formal assessments provided	No	MH only	Yes (ABC, MEDS, Functional analysis, ADL, IADL, CSPIP,
Treatment focus	Community living, skill development. Person centered	Diagnosis and treatment of acute mental health conditions.	Person Centered, Positive psychology, expressive therapies,

	approach, sometimes implement PBSPs. Collaboration with the system of support is key	Identification and treatment of acute medical conditions may also occur. Follow up service and treatment recommendations also provided	health and exercise, assessment of communication, PBS and coping skill development. Consultation and collaboration with system of support is key
24 hour awake staffing	variable	Yes	Yes
Nursing 24 hours	no	Yes	No access to 24 hour supports arranged as needed
MD prescribes on site	No, Community prescriber	Yes	No, Community prescriber MD consultant
Comprehensive discharge summary and follow-up	No	Limited summary some follow-up	Yes
Supported by START team	Yes	Yes	Yes
Satisfaction surveyed	Sometimes	Sometimes	Yes
Transitional in home supports at discharge	No	No	Yes as needed

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Attachment 2: **START STAKEHOLDER PERCEPTION SURVEY**

In order to provide the best possible services, START needs to know what you think about the services you received during the last six months and the people who provided it.

1. When was your most recent encounter with START?
   Within the last week _____
   Within the last month _____
   Within the last three months _____
   Within the last six months _____
   Within the last year _____

2. What service/s did you receive from START? **(Check all that apply.)**
   Consultation _____
   Crisis intervention _____
   Crisis plan development _____
   Team planning _____
   Transition planning support _____
   Caregiver education and training _____
   Planned respite _____
   Crisis respite _____

3. During a crisis what type of response was provided by START? **(Check all that apply.)**
   Phone consultation _____
   On site consultation _____
   On site crisis intervention _____
   No response _____

4. What was the outcome of START intervention?
   Was able to stay at home _____
   Went to crisis respite _____
   Was admitted to a community hospital _____
   Was admitted to a state hospital _____
   You were connected to someone else who could help you? _____

	Extremely	**Very**	**Slightly**	**Not at all**
5. In general, how timely was the START response to your request for assistance during a crisis?	○	○	○	○
6. Were you satisfied with the outcome that START provided?	○	○	○	○
7. In general, how helpful was START involvement to you?	○	○	○	○
8. How knowledgeable was the START Coordinator who helped you?	○	○	○	○
9. How helpful was START in the development of a crisis plan?	○	○	○	○
10. How effective was the crisis plan?	○	○	○	○

11. How timely was the development of the crisis plan? ○ ○ ○ ○

	Ex**tremely**	**Very**	**Slightly**	**Not at all**	others
12. How effective was START in training providers in the crisis plan?	○	○	○	○	
13. Were training and education events helpful?	○	○	○	○	
14. Was staff knowledgeable of topic/s presented?	○	○	○	○	
15. How helpful were the activities provided at the START respite house?	○	○	○	○	
16. How knowledgeable was staff of the START respite house?	○	○	○	○	
17. Overall, how satisfied are you with the services you received through START?	○	○	○	○	

18. Would you recommend START services to others? Yes _____ No ___

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Attachment 3: **START ADULT CONSUMER/FAMILY PERCEPTION SURVEY**

In order to provide the best possible services, START needs to know what you think about the services you received during the last six months and the people who provided it.

1. When was your most recent encounter with START?

Within the last week _____
Within the last month _____
Within the last three months _____
Within the last six months _____
Within the last year _____

2. What service/s did you receive from START? **(Check all that apply.)**

Consultation _____
Crisis intervention _____
Crisis plan development _____
Team planning _____
Caregiver education and training _____
Planned respite _____
Crisis respite _____

3. During a crisis what type of response was provided by START? **(Check all that apply.)**

Phone consultation _____
On site consultation _____
On site crisis intervention _____
No response _____

4. What was the outcome of START intervention?

Was able to stay at home _____
Went to crisis respite _____
Was admitted to a community hospital _____
Was admitted to a state hospital _____
You were connected to someone else who could help you? _____

	Extremely	**Very**	**Slightly**	**Not at all**
5. In general, how timely was the START response to your request for assistance during a crisis?	○	○	○	○
6. Were you satisfied with the outcome that START provided?	○	○	○	○
7. In general, how helpful was START involvement to to you?	○	○	○	○
8. How knowledgeable was the START coordinator who helped you?	○	○	○	○
9. How helpful were the activities provided at the START respite house?	○	○	○	○
10. How knowledgeable was staff of the START respite house?	○	○	○	○
11. Overall, how satisfied are you with the services	○	○	○	○

you received through START?

12. Would you recommend START services to others? Yes _____ No _____

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Attachment 4: Region 1 Report

HPR I

Virginia START

Annual Report
On Services Delivered
July 1, 2012-June 30, 2013

Background

Virginia Health Planning Region I chose to implement START by procuring a contracted vendor through a competitive Request for Proposal process. Through this process, Easter Seals UCP was selected to implement the program and a contract was executed in May of 2012. Since that time, the program has made tremendous progress but has faced many challenges.

Challenges in start-up

As a new provider of this type of service in Virginia, becoming a licensed provider was the initial challenge faced by ESUCP. This process took a full seven months to complete and the program became licensed in the latter part of December, 2012. During the months prior to being licensed, a START Director was hired in July, 2012, to begin hiring, training and preparing staff for service provision upon licensure. The program worked towards the goal of implementing all components of START including assessment and prevention services, Cross Systems Crisis Planning, Clinical Education Team meetings, 24/7 crisis response, and both in-home and residential respite services. Construction on the respite facility was completed in July, 2012 and staff began preparing the facility for use as of August, 2012. The program became fully operational in January, 2013.

Hiring qualified staff has been another challenge for the program. The original Director was dismissed in January, 2013 and recruitment for a Clinical Director had been unsuccessful up to that time. Thus, key leadership positions went unfilled for extensive periods of time during the year. Four Coordinator positions were filled by October, 2012 and recruitment of 2 additional Coordinators continued throughout the year. In addition to recruiting a Licensed Clinical Psychologist to fill the Clinical Director's position, efforts to recruit master's level, licensed staff have been largely unsuccessful. The program adapted by hiring a Licensed Professional Counselor to fill the Clinical Director's position with supervision from a North Carolina Clinical Psychologist. However, as of July, 2013, the Clinical Director resigned and this position remains unfilled at this writing. By June, 2013, two Team Leaders had been identified and six Coordinators were hired. However, the program continues to experience some turnover in these positions. A new, highly qualified Director was hired in April, 2013.

Finally, the demand for services has been overwhelming, particularly in light of the lack of consistent leadership for the program. In January of 2012, when the program began delivering services, there were 18 referrals and 2 individuals made use of the respite facility. By the end of the fiscal year six months later, the program had received 134 referrals and the respite facility beds were running consistently at capacity. The respite facility was closed for 2 weeks from June 24, 2013 until July 5, 2013 to complete renovations to expand the sensory room and relocate the laundry room to better accommodate program needs.

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Client Data

The following represents data from referrals received from July 1, 2012 through June 30, 2013. There were a total of 137 client records entered into the SIRS system during this time period. Of these referrals, only four were not accepted for START services due to not meeting eligibility criteria and were referred to other non-START services.

It should be noted that the region is behind in SIRS data entry to date. However, efforts have been under way to ensure that data is up to date and this is a primary goal for the first quarter of fiscal year 2014. The following data provides key information based on the population served by HPR I START in FY13 and appears to be an accurate representation of the population served in spite of not all data on every client being entered into SIRS at the time of this report.

Gender

As indicated in the table below, the split between males and females referred to START is almost even.

Gender	Number	%
Female	68	49.64%
Male	69	50.36%
Total		100.00%

Age

The age range of referrals was 18-67 years with an average age of 36 years. However, it should be noted that the most common age reported (mode) was 25 years. Transitional youth are most commonly referred for START services. It will be important to monitor this to see if the region follows national trends as the needs and resources of transitional youth versus older adults may vary.

Age	Descriptive Statistics for Individuals by Age
Oldest Age	67
Youngest Age	18
Mean Age	35.95
Median Age	33
Mode Age	25

Level of Intellectual Disability

The majority (78.67%) of individuals referred to START in HPR I had a mild to moderate intellectual disability. Individual referred with no intellectual disability noted may be due to lack of information at the time of referral or may represent individuals with a developmental disability but not ID.

Level of Intellectual Disability	Number of Individuals by level of ID reported	Percent of Individuals by level of ID reported
Normal Intelligence	1	0.74%
Borderline	2	1.47%
Mild	63	46.32%
Moderate	44	32.35%
Severe	18	13.24%
Profound	7	5.15%
None Noted	1	0.74%
Total	136	100.00%

Mental Health Diagnoses at the Time of Referral

Of the 137 individuals entered into the database, a total of 127 (93.4%) had mental health diagnoses reported. It is noteworthy that 33% had a diagnosis of autism. The distribution of diagnoses is consistent with other START populations in the U.S. where the primary issues are mood and anxiety disorders. However, it is also noteworthy that another 20.31% reported Impulse Control Disorder, 25% report psychotic disorders and 10% reported an Axis II diagnosis, all of which are above the national average for this population. Psychotic disorders and Personality disorders are often misdiagnosed in the IDD population due to misinterpretation of symptoms such as self-talk. We will monitor over time and hope to see a reduction in these diagnoses as we provide training and consultation to the system. Only 9 individuals reported no mental health diagnosis.

Psychiatric Diagnosis	**Number of individuals by current psychiatric diagnoses reported**	**Percent of individuals by current type of psychiatric diagnosis reported**
Anxiety-all	35	27.34%
Autism-all	33	25.78%
Childhood-all	20	15.62%
Mood-all	54	42.19%
Psychotic—all	25	19.53%
Adjustment disorder	7	5.47%
Eating disorder	0	0.00%
Fictitious/Somatoform	2	1.56%
Impulse Control Disorder	26	20.31%
Personality disorder (Axis II)	13	10.16%
Sexual/Gender Identity	0	0.00%
Substance Abuse Disorder	0	0.00%
Other	9	7.03%
Total Diagnoses Reported	224	175.00%

Total individuals with reported psychiatric diagnoses	127	93.4%
Mean diagnoses reported	1.81	n/a
Mode diagnoses reported	1	n/a
1 diagnosis reported	56	43.75%
2 diagnoses reported	48	37.50%
3 diagnoses reported	17	13.28%
4 diagnoses reported	6	4.69%
5 diagnoses reported	1	0..78%
Total individuals reporting no diagnosis	9	7.03%

Other Disabilities Reported at the Time of Referral

Other disabilities reported notes particular vulnerabilities that may be present for individuals served by HPR I START. It will be important to watch for trends in order for consideration of these vulnerabilities to be included in future reporting and planning.

Other Disabilities	**Number of individuals by current disabilities reported**	**Percent of individuals by current disabilities reported**
Hearing	4	36.36%
Physical/ambulation	0	0.00%
Smell	0	0.00%
Speech/Communication	6	54.55%
Vision	4	36.36%
Other	0	0.00%
Total Individuals reported	**14**	**127.27%**

Medical Diagnoses at the Time of Referral

Data regarding medical issues will be important to track over time as the region monitors the medical needs of individuals in the community and seeks to fill gaps in services available and potential shortages of service providers in some communities within the region for this population. Noteworthy in the table below is that 59.09% of individuals reporting a medical diagnosis had a neurologic condition. The other most common medical diagnoses reported were cardiovascular, endocrine and gastrointestinal conditions.

Medical Diagnosis	Number of individuals by current diagnosis reported	Percent of individuals by current diagnosis reported
Cardiovascular	18	20.45%
Dental/Oral	2	2.27%
Dermatology/Skin	3	3.41%
Ear/Nose/Throat	6	6.82%
Endocrine	15	17.05%
Eye Disorders	3	3.41%
Gastro/Intestinal	21	23.86%
Genitourinary	6	6.82%
GYN/Pregnancy	2	2.27%
Hematology/Oncology	2	2.27%
Hepatic/Biliary	1	1.14%
Immunology/Allergy	13	14.77%
Infectious disease	3	3.41%
Neurologic	52	59.09%
Nutritional disorders	4	4.55%
Pulmonary disorders	8	9.09%
Other	20	22.73%
Total Diagnoses Reported	179	

Noteworthy in the table below is that just over half of individuals reported no medical diagnosis at the time of referral. It is unclear whether this information was unavailable at the time of referral or whether this indicates some other variable to be determined. Chronic medical conditions can have a large impact on psychological well-being and it will be important to develop an accurate picture of the nature and prevalence of medical diagnoses in the population served by HPR I START.

Medical Diagnosis	Number of individuals by current diagnosis reported	Percent of individuals by current diagnosis reported
Total individuals with reported medical diagnoses	88	46.81%
Mean diagnoses reported	2.14	n/a
Mode diagnoses reported	1	n/a
1 diagnosis reported	37	42.05%
2 diagnoses reported	26	29.55%
3 diagnoses reported	12	13.64%
4 diagnoses reported	7	7.95%
5 or more diagnoses reported	6	6.82%
Total individuals reporting no diagnosis	49	55.68%

Residential Information

Residential Setting at Time of Referral

At the time of referral the majority of individuals in HPR I were living either in a group home (49%) or in their family home (32.31%).

Living situation at time of referral to START	Number of individuals by type of living situation reported	Percent of individuals by type of living situation reported
Assisted Family Living (ALF)	11	8.46%
Community ICF/MR	1	0.77%
Family Home	42	32.31%
Foster Care Home	1	0.77%
Group Home	49	37.69%
Homeless	0	0/00%
Independent Living	5	3.85%
Jail	0	0.00%
Psychiatric Hospital	2	1.54%
State operated training center	6	4.62%
Supervised Apartment	0	0.00%
Supported Living	4	3.08%
Other	9	6.92%
Total	**130**	**100.00%**

The table below is significant in that about 41% of the individuals served by the region have had multiple residential placements over the 5 years prior to referral to START. Instability in housing and lack of permanence is something that should be monitored.

Multiple residential placements over the last 5 years at point of referral	Number of individuals with multiple placements	Percent of individuals with multiple placements
No	80	58.39%
Yes	57	41.61%
Total	137	100.00%

Psychiatric Hospitalizations

A significant number of START service recipients in the region have been admitted to psychiatric hospitals in the past year. These percentages increase when the numbers of psychiatric admissions for the previous 5 years are tabulated.

Psychiatric hospitalizations in the last year (at point of referral)	Number of individuals reporting one or more hospitalizations in the last year	Percent of individuals reporting one or more hospitalizations in the last year
No	95	69.85%
Yes	41	30.15%
Total	**136**	**100.00%**
Range	1 - 4	
Mean	1.54	

Psych hospitalizations in the last 1-5 years (at point of referral)	Number of individuals reporting one or more hospitalizations in the last 1 - 5 years	Percent of individuals reporting one or more hospitalizations in the last 1 - 5 years
No	88	64.71%
Yes	48	35.29%
Total	**136**	**100.00%**
Range	1 - 10	
Mean	2.69	

Number of Prior Psych Hospitalizations	Total number of hospitalizations	Percent of prior psychiatric hospitalizations
In past 1 to 5 years	129	67.19%
In past year	63	32.81%
Total	**192**	**100.00%**

Services Provided

Emergency/Crisis Services

The program began providing 24/7 emergency response and crisis intervention services in January of 2013. According to SIRS data, between January and June of 2013, the program responded to 32 emergency/crisis referrals involving 22 individuals throughout the region. Eight of these individuals (36%) were referred for more than one crisis contact. There is some discrepancy between the SIRS report and program hand tallied data regarding the number of crisis/emergency responses. This may be due to the fact that the Coordinators did not begin entering data fully into SIRS until April, 2013. The program likely responded to more than the 32 referrals recorded in SIRS.

Crisis Referral Source

The majority of emergency/crisis referrals were from community residential providers (43.75%). This may speak to the need for training for community providers to be able to recognize triggers and stages that lead to a crisis. Many providers have already begun to request training.

Source of Contacts/Referrals for Services	Number of Sources	Percent of Sources
Case Manager/Service Coordinator	5	15.62%
Community psychiatric inpatient	3	9.38%
Emergency services/Mobile crisis team	4	12.50%
Day/Vocational service provider - Community	0	0.00%
Family member	3	9.38%
Friend	0	0.00%
Hospital emergency department	3	9.38%
Law enforcement	0	0.00%
Legal advocate	0	0.00%
Residential provider - Community	14	43.75%
School	0	0.00%
Self	0	0.00%
State operated I/DD center	0	0.00%
State psychiatric hospital	0	0.00%
Other	0	0.00%
Total	**32**	**100.00%**

Problems reported at the time crisis contact

Data indicated that the primary problem reported at the time of crisis is aggression followed by mental health symptom, and a decrease in the ability to participate in daily functions. About 15% of referrals for a crisis were at risk of losing their placement.

Presenting problems at time of referral to emergency/crisis services	Number of Problems	Percent of Total Problems Reported	Number of Individuals Reporting Problems	Percent of Individuals Reporting Problems
Aggression - all	81	43.32%	22	22.92%
Mental health symptoms - all	37	19.79%	17	17.71%
At risk of losing placement	19	10.16%	14	14.58%
Decrease in ability to participate in daily functions	18	9.63%	16	16.67%
Diagnosis and treatment plan assistance	9	4.81%	9	9.38%
Family needs assistance	4	2.14%	4	4.17%
Self-injurious	14	7.49%	9	9.38%
Transition from hospital	3	1.6%	3	3.13%
Other	2	1.07%	2	2.08%
Total presenting problems	**187**	**100%**		**100%**

Reported response time following emergency request

On average, the region was able to meet the required response time of less than three hours. This is in spite of turnover in Coordinator positions and managing the on-call for the large geographic region. The region anticipates being able to meet the two hour requirement in FY14.

Response time	Number of events by response time	Percent of events by response time
Less than 2 hours	16	51.61%
2 hours or more	15	48.39%
Average response time	1 hour(s), 42 minute(s)	

Outcomes/primary dispositions during the crisis contact

There were a variety of dispositions reached on individuals when a crisis response was made. Just over 31% of individuals referred through a crisis contact were admitted for an emergency respite admission. Approximately 31% were admitted to a higher level of care at either a community mental health in-patient unit or a state facility. Just over 18% were able to maintain their current setting.

The region continues to find getting a disposition on individuals needing a higher level of care in a crisis challenging. A number of behavioral health units have refused admission for individuals with intellectual disabilities, so there have been times when individuals have spent more than 24 hours in emergency rooms waiting for a disposition. This will be an area of focus for the coming year.

Final outcome/disposition of referral to emergency/crisis services	Number of Outcomes	Percent of Total Outcomes
Community mental health in-patient unit admission	7	21.88%
Crisis stabilization unit/bed	0	0.00%
In-home respite support	5	15.62%
Maintain current setting	6	18.75%
Referral out for services	1	3.12%
START emergency respite admission	10	31.25%
START planned respite scheduled/provided	0	0.00%
State operated/private ICF/MR or other I/DD facility	1	3.12%
State psychiatric hospital admission	2	6.25%
Other	0	0.00%
Total outcomes	32	100.00%
Total individuals with reported final outcome/disposition	22	

Emergency Respite

A total of 23 individuals were admitted for Emergency Respite admission. Approximately 5 individuals were denied respite admission due to a higher level of medical or psychiatric care needed or the facility was at capacity.

Individuals admitted to respite stayed for a range of 2 to 35 days with the average length of stay being 21.32 days. The table below outlines presenting problems at the time of referral for emergency respite admission.

Presenting Problems at time of referral to emergency respite	Number of Problems	Percent of Total Problems Reported	Number of Individuals Reporting Problems	Percent of Individuals Reporting Problems
Aggression - all	60	37.5%	16	17.2%
Mental health symptoms - all	23	14.37%	15	16.13%
At risk of losing placement	19	11.88%	15	16.13%
Decrease in ability to participate in daily functions	20	12.5%	16	17.2%
Diagnosis and treatment plan assistance	12	7.5%	11	11.83%
Family needs assistance	7	4.38%	6	6.45%
Self-injurious	10	6.25%	7	7.53%
Transition from hospital	9	5.63%	7	7.53%
Other	0	0%	0	0%
Total presenting problems	**160**	**100%**	**93**	**100%**

Planned Respite

A total of 13 individuals were admitted for planned respite stays. Individuals stayed anywhere between 2 and 18 days on planned admission with an average length of stay of 5.56 days. As the table below indicates, it is significant that the most common reason for a planned admission was the family needing assistance.

Presenting problems at time of referral to planned respite	Number of Problems	Percent of Total Problems Reported	Number of Individuals Reporting Problems	Percent of Individuals Reporting Problems
Aggression - all	14	22.22%	7	18.42%
Mental health symptoms - all	15	23.81%	8	21.05%
At risk of losing placement	2	3.17%	1	2.63%
Decrease in ability to participate in daily functions	12	19.05%	9	23.68%
Diagnosis and treatment plan assistance	2	3.17%	2	5.26%
Family needs assistance	16	25.4%	9	23.68%
Self-injurious	2	3.17%	2	5.26%
Transition from hospital	0	0%	0	0%
Other	0	0%	0	0%
Total presenting problems	**63**	**100%**	**38**	**100%**

In-Home Respite

The demand for in-home respite was quite high with 23 individuals referred on 73 separate occasions. Eleven of the individuals referred received more than one instance of in-home support. The demand, at times, exceeded capacity due to lack of enough staff to provide the service. In-home services were provided at a range of 2 to 50 hours of service per incident with the average length of service being 6.4 hours. The region provided a total of 469 hours of in-home support during the reporting period.

The START program continues to define exactly what the service definition and criteria for in-home supports will be statewide. It may be that the region provided more than will ultimately be needed and will be able to meet the demand for in-home with current staffing. This will continue to be monitored.

Additional START Clinical Team Services

The START clinical team has been able to provide a variety of START services throughout the region during the past year. There have been five clinical education team (CET) presentations in various locations throughout the region. The region has an experienced and knowledgeable

Medical Director who has provided numerous consultative services. The primary challenge on the clinical team is the lack of a permanent Clinical Director and turnover in Coordinator positions. At the time of this report, the Clinical Director position and two Coordinator positions are vacant. Filling these positions is a primary goal for the coming year.

The Clinical Team provided a variety of assessment services. During the past year the following were completed:

Type of Assessment/Plan	Number Completed
Provisional Crisis Plan	**126**
Cross System Crisis Plan (CSCP)	**13 (in draft form)**
Comprehensive Service Evaluation (CSE)	**4**
Aberrant Behavior Checklist (ABC)	**126**
MED	**21**
Consultation to system provided by Medical Director	**43**
Admission/Discharge summaries written by Respite Director	**15**

Community trainings have been conducted on several occasions. A presentation was given at the statewide meeting of mental health crisis stabilization units. The START Director has attended the regional meetings of the Emergency Services Managers on an ongoing basis. Dr. Joan Beasley provided training on assessing individuals with ID in crisis to the regional Emergency Services managers in June of 2013 during her consultative visit to the region. HPR I START participated in three CIT trainings in the Fredericksburg area, providing training on crisis intervention with individuals with ID/DD.

List of Affiliation and Linkage Agreement Completed

Easter Seals UCP/START has finalized Linkage Agreements with four of the eight CSB Emergency Services Departments in the Region. These include:

Region Ten CSB

Rappahannock Area CSB

Harrisonburg Rockingham CSB

Horizon Behavioral Health

The four additional CSBs have been trained on collaboration with START but have not formally signed Linkage Agreements. A meeting is schedule with Valley CSB on September 3, 2013 to work with their Emergency Services manager, who is the regional chair for HPR I ES Council, to review language in the current Linkage Agreement and further detail the collaborative process between START and emergency services. Once finalized, this will be sent to all eight CSBs in

the region for review. Additional training will be scheduled with each CSB as roles are clarified and protocols are refined.

Additionally, the region has already begun negotiations with Western State Hospital to develop a Linkage Agreement. Local private hospitals with behavioral health units in the region will be targeted in FY14 as a resource for further Linkage Agreements.

Goals for FY14

GOAL	ACTION STEPS	TARGET DATE OF COMPLETION
Continue recruitment and hiring of qualified staff focusing on need for a Clinical Psychologist and licensed staff.	Develop relationships with local universities with relevant training programs for Masters and PhD students to include at a minimum UVA, JMU, VCU and perhaps provide internship opportunities	June 30, 2014 and on-going as needed
Ensure that data entry into SIRS is up to date and accurate in order for the region to be able to accurately track trends and outcomes and assess performance measures	START Director and Regional PM will work together to direct START Coordinators and Clinical Team to enter data into SIRS in a timely and accurate manner.	September 1, 2013 and ongoing
Increase the number of signed Linkage Agreements with regional stakeholders to include all 8 regional CSB Emergency Service Teams, local and state hospitals, and private providers in order to strengthen the system's knowledge and understanding of START services, further develop collaborative relationships in the community and address continuum of care gaps	At a minimum, agreements should be signed with all 8 CSB Emergency Service Teams in the region. By the end of FY14, have Linkage Agreements in place with UVA Hospital, Western State Hospital, and at least 3 private providers. Participate in the statewide joint MH/ID Council meetings to address systemic gaps in crisis care and clients with IDD having access to local psychiatric acute care facilities.	October 1, 2013 June 30, 2014 Beginning July, 2013 and ongoing

Ensure that the region is maximizing billing opportunities for all services.	ESUCP will begin billing for ID Waiver Crisis Intervention and Crisis Supervision along with MH SPO Crisis Intervention and Crisis Stabilization when appropriate for consumers who meet eligibility criteria	August, 2013
Continue to assess the START respite facility's needs to ensure the program can run with maximum efficiency.	Address parking issue by increasing parking capacity.	October 2014
Increase clinical skills of Coordinators, Clinical Team and Respite Staff	Participate in mentoring program with START National consultants and in collaboration with Region III	To begin July, 2013 and ongoing
Begin conducting Satisfaction Surveys for both providers and individuals receiving START services	Utilize statewide Satisfaction Survey under development and distribute to providers, families and individuals received services on an annual basis.	To begin October, 2013

A program of the Institute on Disability/UCED, University of New Hampshire

Attachment 5: Region 2 Report

Virginia START Region 2 Annual Data Report
For implementation of services between 7/1/12-8/30/13
Philippe Kane, Psy.D., START Director Region 2

Implementation of VA START Services Summary

Following is an analysis of cumulative data reported in SIRS from 7/1/12- 8/30/13. In some cases, data has not been reported or is under reported. However, given those limitations in the process, the data in this report best exemplifies Region 2 and the service implementation thus far.

Summary

It is important to note that START Region 2 was licensed to provide services in the community beginning January of 2013 and respite services were licensed to begin February 14, 2013. Due to these commencement dates of Region 2 START services, the data reflects services provided within a time frame of 4-5 months within 2013.

Within the FY 2013, Region 2 entered 95 individuals into the SIRS.

Population information

The following provides key demographic information about the population served by VA START Region 2.

Gender and Age

Region 2 START data indicates that there are 64 males and 31 females being served. The median age is 26.5, mode age is 23, mean age is 32.76 while the youngest age reported is 18 and eldest being 78.

Level of Intellectual Disability

The data collected in regard to levels of Intellectual Disability are as follows:

Normal Intelligence= 4
Borderline =1
Mild=45
Moderate=21
Severe=7
Profound=6
None Noted=9

The above data indicates that 4 individuals have normal intelligence and 9 individuals fall into the None Noted category. It is likely that all these individuals fall into the Developmentally Disabled (DD) category.

Funding Source

56 individuals receive funding through I/DD Waiver, 22 have Medicaid, 4 have Medicare, 3 have private insurance and 3 individuals have no insurance.

Living Situation at the time of referral

At the time of referral, 39 individuals were residing within a family home and 39 individuals were living in a group home. The remainder of individuals referred had the following living situations:

Assisted Family Living-1
Community ICF/MR-2
Foster Care Home-3
Psychiatric Hospital- 3
State Operated I/DD center-1
Supervised Apartment-2
Supported Living-1
Other-2

Data indicates that 22 individuals out of 95 referrals have had multiple residential placements within the last 5 years.

Psychiatric Hospitalizations

Region 2 SIRS data regarding past psychiatric hospitalizations indicates that 22 out of 95 individuals have had one or more hospitalizations in the past year. Overall within this sample, there were 37 hospitalizations in the past year. 21 out of the 22 individuals with a history of hospitalization have had one or more hospitalizations in the last 1-5 years with an overall number of 56 hospitalizations in the past 1-5 years.

Legal Guardianship

Data indicates that 54 of 95 individuals have legal guardianship which is 56.84% of the sample. 43.16% of individuals did not have legal guardianship at the time of referral.

Mental Health Diagnoses at time of referral

The total number of individuals entered into the Region 2 SIRS database was 95. Of those entered into SIRS, 69 (50%) had mental health diagnoses reported. This number is likely an under report of mental health diagnosis. At the time of referral, many referrals describe “challenging behaviors” such as aggression, self-injurious behavior and/or verbal threats. At the time of referral, mental health

symptoms may be overshadowed by the challenging behaviors described, when in actuality the challenging behaviors are a manifestation of mental health disorders such as depression, anxiety and other disorders that would lead one to externalizing behaviors. The breakdown of diagnoses is as follows:

Anxiety (all)=22
Mood (all)=25
Autism (all) =22
Childhood (all) 13
Psychotic (all) =14
Adjustment Disorder =3
Eating Disorder=1
Impulse Control Disorder=8
Personality Disorders=3

27 individuals are reportedly diagnosed with 1 diagnosis
20 individuals are reportedly diagnosed with 2 diagnoses
17 individuals are reportedly diagnosed with 3 diagnoses
5 individuals are reportedly diagnosed with 4 diagnoses

Other Disabilities:

Hearing=2
Speech/Communication=5
Vision=1
Other=3

Medical Diagnoses:

Out of the 95 referrals to START Region 2, 49 individuals reportedly have a medical diagnosis. Data suggests that there is a trend in relation to neurologic difficulties (14 individuals). This may be due to the frequently observed comorbidity of seizure disorder with autism spectrum disorder. The category of "Other" contained 25 endorsements which was the highest endorsed. It is unclear what medical diagnoses may fall into this category but further research would be recommended. The remaining endorsed medical difficulties are listed below:

Cardiovascular=7
Dermatology=3
Ear/Nose/Throat=1
Endocrine=4
Eye=4
Gastro=4
GYN=1
Allergy=1
Pulmonary=5

Most individuals within this sample had only one medical diagnosis (67.35%). Individuals with 2 diagnoses reported (16.33%), three medical diagnoses reported (12.24%) and four medical diagnoses reported (2.04%).

Legal Involvement (Stays in jail)

A small number of individuals spent time in jail. 7 individuals had one or more jail stays within the past year and 7 individuals had one or more jail stays within the past 1-5 years.

Services Provided

A. Mobile crisis services commenced in January 2013 and respite operations began on February 14, 2013. Listed below is a more specific reference to services provided:
    1. **Emergency/Crisis Services**
       There were 9 documented emergency responses within the last fiscal year. START coordinators have reported emergency responses with significant outcomes such as an individual being stabilized, admitted to respite or the hospital. Coordinators have been less likely to report crisis stabilization done over the phone.
    2. **Emergency Respite**
       There were 4 recorded emergency respite stays within this fiscal year which helped to prevent hospitalizations that appeared to be unnecessary (not a lethal harm to themselves or others). It has been reported that all of the individuals admitted on an emergency basis were exhibiting externalized behaviors such as aggression to others or experiencing suicidal ideation due to depressive symptomology. A large spike in emergency respite admissions has been observed since the new fiscal year has began, likely due to better working relationships with emergency services and local psychiatric hospitals. Our program denied three individuals from being admitted to emergency respite. Both individuals were felt to be in need of more intensive stabilization by a hospital and on another occasion the home was filled at capacity resulting in the denial of an individual being admitted.
    3. **Planned Respite**
       There were 16 planned respite admissions. START coordinators in coalition with families and support coordinators were able to successfully identify early stressors and triggers in individuals that may have escalated to crisis levels. This has been a successful way to help keep individuals living in the community when they are at risk for losing day or residential placements or at risk for more significant mental health symptoms to occur.
    4. **In-Home Respite**
       There have been 5 in home respite stays where respite counselors have been able to observe individuals in their residential environment and work with families to give them

more tools to help deescalate crisis situations in the home. This service has included some short term counseling and consultation for individuals and their families.

B. Assessments and Plans :
   a. Cross System Crisis Plans completed= 35
   b. Comprehensive Service Evaluations completed = 12
   c. Aberrant Behavior Checklist (ABC) conducted = 26
   d. MEDs conducted= 67 on 21 individuals
   e. Consultations to system provided by Medical Director= 36
   f. Admission/discharge summaries written by Respite Director=50
   g. Clinical Education Team trainings = 5

Training Provided

START Region 2 has participated in training many systemic partners in the community. Training and education in regard to the START program has been provided to the five emergency service departments in Northern Virginia (Alexandria, Fairfax, Arlington, Loudoun and Prince William County). Additionally, START Region 2 has provided training to CIT department in Loudoun County in relation to working with individuals with autism spectrum disorder and working with those that may have intellectual disabilities. START Region 2 facilitated a similar training for Dominion hospital staff in regard to individuals with autism spectrum disorder. Training has also been provided for the case managers at the five local community services boards and for DD case managers at the Arc of Northern Virginia. Further education about the START program was provided at a residential provider meeting held by the state of Virginia. Upcoming training includes a workshop provided to families through the Arc of Prince William County and training for the Arlington County sheriff's department.

Following is the information reported by Region 2 with regard to linkage agreements they have obtained to date:

Region II Linkage & Affiliation Agreements:

Fairfax / Falls Church Emergency Services
- Prince William County ES
- City of Alexandria ES
- Loudoun County ES
- Arlington County ES

Fairfax / Falls Church Community Services Board

A program of the Institute on Disability/UCED, University of New Hampshire

START Region 2 Goals for FY2014

Although the START team in Region 2 has only been operational for close to seven months, a lot has been accomplished in hiring and training team members as clinical coordinators and as respite counselors. There is only one vacancy for a position within the START Region 2 program. In addition we have witnessed the average daily respite census increase quickly since opening as the census is now 5-6 guests per day on average in a 6 bed respite home. In looking toward achieving future goals, the team is actively working to complete cross system crisis plans within 30 days of admission to START. When the program first became licensed to operate, there was a backlog of referrals to quickly attend to in regard to crisis prevention and crisis stabilization. With a fully equipped staff who have now had practice creating comprehensive yet systemic plans, the pace of providing plans to the community will likely increase. Additionally, more training will be provided to community partners like behavioral health partners, hospitals, and law enforcement to help create more linkage agreements/affiliations. Lastly, the team will continue to advocate for the individuals we work with and will continue to educate the community and families on how to develop and utilize the tools in working with individuals with I/DD from a person centered perspective while not ignoring their mental health symptomology. This will require further education and training to the community that will develop the competencies to work effectively and systemically in serving the population we serve. Finding ways to track and collect data on the efficacy of the program is also a future goal to aid in providing the best evidence based practices possible.

START Region 2 Goals Itemized

- Fill remaining position and maintain full staffing. START Certification completed with all START Coordinators
- Maintain 5-6 guest average daily census
- Complete all Cross System Crisis Plans within 30 days of admission to START
- Expand training opportunities to the community partners in Region 2
- Develop outcome measures that address the efficacy of the Region 2 START Program

Attachment 6: Region 3 Report

FY13 VA START Regional Report
Region III
July 1, 2012 – June 30, 2013

Region III START began initial operations in June 2012
Community based services including START coordinators/ community based crisis/respite providers working within systems of care including private homes, ALFs, training centers, psychiatric facilities, day programs, Etc.

START Respite house began operations November 2012. Four beds to current operation of six bed availability. Beds include 3 respite/3 crisis or emergency beds.

Crisis on call began July 2012, during regular business hours with 24/7 response, fully operational November 2012 across the region.

Region III covers over 11,668 square miles of primarily rural Southwestern Virginia. Of Virginia's 8,001,024 residents, 1,103,923 reside in this region. There are 25 Counties and 9 Cities within the region. Much of the terrain in Region III is very rural and mountainous.
Nearly the entire region is considered a Mental Health Professional Shortage Area by the Virginia Department of Health.
Nearly half of the region is a Primary Care Health Professional Shortage Area.
1/3 of the localities have a shortage of Dental Health Professionals

Region III has experienced difficulty in staffing areas that have included turnover in positions that include both facility and community based areas. There have also been barriers to hiring due to difficulty in qualified staff applying for positions.

Region III has not had a full time qualified clinical director in place until August 2013. Several coordinator positions have remained open due to lack of qualified applicants applying for the positions.

Utilizing of a FT Nurse Practitioner, with a PT psychiatrist has been and extremely beneficial combination. Medical needs have been a significant concern for individuals receiving START services.

C. Total number referred/served- **134**

The data is not consistent with the SIRs data at this point. We are working to ensure data is input into the system consistently. It is an ongoing process to ensure data is consistent in both systems.

D. Demographic data- 134

E. Services provided (including when the service started in your region)

a. Emergency/Crisis Services—Region III provided 124 mobile/community crisis service plans to START and non-START (this is in their first contact and where they are opened into START) individuals. Beginning July 2012.

ES may be involved in these cases where there is question of harm to self or others that cannot be managed safely in their community.

b. Emergency Respite began in Region III in November this service in 2012. **36** individuals were admitted to the START facility following assessment for need of emergency placement due to risk factors, service needs that their primary system was unable to manage to support the individual and prevent loss of housing, psychiatric hospitalization or incarceration. START provides individuals a safe and therapeutic environment where trained staff can further assess each individual guest to stabilize the crisis/emergency and assess for further service needs. While the individual is at START respite the system is also receiving support and education.

c. Planned Respite Region III began providing this service in November 2012. 32 individuals were admitted to the START facility for planned respite to support their systems to receive resource and support for the individuals. Planned respite provides a therapeutic environment for guests.

F. Assessments and Plans – number of:

a. Crisis plans (cross systems) completed 71
b. Provisional plans 133
c. CSEs completed **31**
d. ABCs conducted **32**
e. MEDs conducted **60**
f. Consultations to system provided by Medical Director; **25**
g. Admission/discharge summaries written by Respite Director
64 written by respite director
4 written by clinical director

G. Training provided

37 trainings across the region to
Emergency Services
Group Home staff
Private/CSB providers
Support coordinators/CM

Families
Guardians
Law enforcement/CIT

3 CETs: Autism
Anti-social Personality do in ID/D
Self-Injurious Behaviors in ID/D
This clinical director is scheduling these monthly and I expect this number to increase steadily. This is an area that we have needed to focus on and grow.

H. List of Affiliation and Linkage Agreements completed
Alleghany Highlands Community Services Board
Blue Ridge Behavioral Healthcare
Cumberland Mountain Community Services
Danville-Pittsylvania Community Services Board
Dickenson County Behavioral Health Services
Highlands Community Services
Mt. Rogers Community Services Board
New River Valley Community Services
Piedmont Community Services Board
Planning District 1 Behavioral Health Services

I. Goals for FY14:

- START will provide a CET (clinical education team) training in each of the 10 CSBs to include area providers FY 13/14.
- START will focus on provision of excellent customer service through feedback of respite guest discharge satisfaction surveys and an annual START service satisfaction survey during FY 13/14
- START will meet the 3 hours or less crisis response time for all crisis calls requiring immediate response this FY 13/14.

Age	Descriptive Statistics for individuals by Age
Oldest Age	72
Youngest Age	18
Mean Age	36.49
Median Age	35
Mode Age	21

Gender (Male, Female ONLY)	Number of Individuals by gender reported	Percent of Individuals by gender reported
Female	58	46.40%
Male	67	53.60%
Total	**125**	**100.00%**

Level of Intellectual Disability	Number of Individuals by level of ID reported	Percent of Individuals by level of ID reported
Normal intelligence	3	2.40%
Borderline	2	1.60%
Mild	66	52.80%
Moderate	36	28.80%
Severe	8	6.40%
Profound	6	4.80%
None noted	4	3.20%
Total	**125**	**100.00%**

Funding Source	Number of Individuals by funding source reported	Percent of Individuals by funding source reported
I/DD waiver	65	54.62%
Medicaid	50	42.02%
Medicare	1	0.84%
None	3	2.52%
Private insurance	0	0.00%
Total	**119**	**100.00%**

Living situation at time of referral to START	Number of Individuals by type of living situation reported	Percent of Individuals by type of living situation reported
Assisted Family Living (AFL)	7	5.98%
Community ICF/MR	0	0.00%
Family home	49	41.88%
Foster care home	4	3.42%
Group home	34	29.06%
Homeless	0	0.00%
Independent living	5	4.27%
Jail	1	0.85%
Psychiatric hospital	5	4.27%
State operated I/DD center	4	3.42%
Supervised apartment	0	0.00%
Supported living	6	5.13%
Other	2	1.71%
Total	**117**	**100.00%**

Multiple residential placements over the last 5 years (at point of referral)	Number of individuals with multiple placements	Percent of individuals with multiple placements
No	83	66.40%
Yes	42	33.60%
Total	**125**	**100.00%**

Psychiatric hospitalizations in the last year (at point of referral)	Number of individuals reporting one or more hospitalizations in the last year	Percent of individuals reporting one or more hospitalizations in the last year
No	86	68.80%
Yes	39	31.20%
Total	**125**	**100.00%**
Range	1-15	
Mean	2.36	

Psych hospitalizations in the last 1-5 years (at point of referral)	Number of individuals reporting one or more hospitalizations in the last 1 - 5 years	Percent of individuals reporting one or more hospitalizations in the last 1 - 5 years
No	85	68.00%
Yes	40	32.00%
Total	**125**	**100.00%**
Range	1-15	
Mean	3.6	

Number of Prior Psych Hospitalizations	Total number of hospitalizations	Percent of prior psychiatric hospitalizations
In past 1 to 5 years	144	61.02%
In past year	92	38.98%
Total	**236**	**100.00%**

Legal Guardian	Total Individuals	Percent of individuals reporting
No	77	61.60%
Yes	48	38.40%
Total individuals reporting	**125**	**100.00%**

Psychiatric Diagnoses	Number of individuals by current types of psych diagnoses reported	Percent of individuals by current types of psych diagnoses reported
Anxiety - all	25	24.51%
Autism - all	17	16.67%
Childhood - all	12	11.76%
Mood - all	43	42.16%
Psychotic - all	33	32.35%
Adjustment disorder	5	4.90%
Eating disorder	0	0.00%
Fictitious/Somatoform	1	0.98%
Impulse control disorder	17	16.67%
Personality disorders (Axis II)	9	8.82%
Sexual/Gender identity	0	0.00%
Substance abuse disorder	5	4.90%
Other	10	9.80%
Total diagnoses reported	**177**	
Total individuals with reported psychiatric diagnoses	102	54.84%
Mean diagnoses reported	1.82	N/A
Mode diagnoses reported	1	N/A
1 diagnosis	42	41.18%

reported		
2 diagnoses reported	39	38.24%
3 diagnoses reported	19	18.63%
4 diagnoses reported	1	0.98%
5 or more diagnoses reported	1	0.98%
Total individuals reporting no diagnosis	23	22.55%

Other disabilities	Number of individuals by current disabilities reported	Percent of individuals by current disabilities reported
Hearing	2	16.67%
Physical	2	16.67%
Smell	0	0.00%
Speech/Communication	7	58.33%
Vision	6	50.00%
Other	0	0.00%
Total	**17**	

Medical Diagnoses	Number of individuals by current med diagnoses reported	Percent of individuals by current med diagnoses reported
Cardiovascular	16	20.00%
Dental/Oral	2	2.50%
Dermatology/ Skin	3	3.75%
Ear/Nose/Throat	2	2.50%
Endocrine	19	23.75%
Eye disorders	6	7.50%
Gastro/Intestinal	23	28.75%
Genitourinary	3	3.75%
GYN/Pregnancy	2	2.50%
Hematology/ Oncology	2	2.50%
Hepatic/Biliary	3	3.75%
Immunology/ Allergy	9	11.25%
Infectious disease	2	2.50%
Neurologic	28	35.00%
Nutritional disorders	10	12.50%
Pulmonary disorders	14	17.50%
Other	20	25.00%
Total diagnoses reported	**164**	
Total individuals with reported medical diagnoses	80	47.34%
Mean diagnoses	2.11	N/A

reported		
Mode diagnoses reported	1	N/A
1 diagnosis reported	29	36.25%
2 diagnoses reported	27	33.75%
3 diagnoses reported	15	18.75%
4 diagnoses reported	5	6.25%
5 or more diagnoses reported	4	5.00%
Total individuals reporting no diagnosis	45	56.25%

Primary Caregiver	Total Individuals	Percent of individuals reporting
No	58	
Yes	67	
Total individuals reporting	125	
If yes, type of primary caregiver		
Authorized representative	10	14.93%
Guardian	7	10.45%
Other family member	9	13.43%
Parent	28	41.79%
Self	13	19.40%
Total	**67**	**100.00%**

Secondary Caregiver	Total Individuals	Percent of individuals reporting
No	106	
Yes	19	
Total individuals reporting	125	
If yes, type of primary caregiver		
Authorized representative	2	10.53%
Guardian	1	5.26%
Other family member	5	26.32%
Parent	10	52.63%
Self	1	5.26%
Total	**19**	**100.00%**

State sponsored ICF/MR stays in the last year (at point of referral)	Number of individuals reporting one or more state sponsored ICF/MR stays in the last year	Percent of individuals reporting one or more state sponsored ICF/MR stays in the last year
Yes	8	7.02%
No	106	92.98%
Total	114	100%

State sponsored ICF/MR stays in the last 1-5 years (at point of referral)	Number of individuals reporting one or more state sponsored ICF/MR stays in the last 1 - 5 years	Percent of individuals reporting one or more state sponsored ICF/MR stays in the last 1 - 5 years
Yes	10	8.85%
No	103	91.15%

Total	113	100%

Jailed in the last year (at point of referral)	Number of individuals reporting one or more jail stays in the last year	Percent of individuals reporting one or more jail stays in the last year
Yes	6	5.08%
No	112	94.92%
Total	118	100%

Jailed in the last 1-5 years (at point of referral)	Number of individuals reporting one or more jail stays in the last 1 - 5 years	Percent of individuals reporting one or more jail stays in the last 1 - 5 years
Yes	9	7.69%
No	108	92.31%
Total	117	100%

A program of the Institute on Disability/UCED, University of New Hampshire

Attachment 7: Region 4 Report

Submitted by: Autumn Richardson, MSW

Region IV's VA START program is operated by the Richmond Behavioral Health Authority and is made up of the following localities: Henrico, Richmond City, Chesterfield, District 19, Hanover, Crossroads, Southside and Goochland Powhatan. The program provides Crisis response, mobile support, consumer monitoring and will begin providing planned and emergency respite supports in FY 14.

A. **Number Served**	
• Total number referred / served:	139
Referrals by Month:	
• May 2012	2
• June 2012	22
• July 2012	15
• August 2012	34
• September 2012	11
• October 2012	5
• November 2012	4
• December 2012	5
• January 2013	8
• February 2013	7
• March 2013	6
• April 2013	11
• May 2013	3
• June 2013	6

A large number of Region IV's referrals came in during the first few months of the program's inception therefore the START team has worked throughout the year to learn the needs of each of the individuals, developing collaborative relationships with planning partners, completing the intake and assessment process and implementing crisis plans for individuals. Crisis services were delivered for individuals unknown to START as well as for referred individuals as requested/appropriate.

B. Demographic data		
• Age	Average Age:	31.46 years
• Gender	Female: Male:	49.12% 50.88%
• % of Individuals by Level of ID	Mild: Moderate: Severe: Profound: *Other:	57.52% 26.55% 6.19% 5.31% 4.41%
• Funding Source	ID Waiver: Medicaid: Medicare: None: Private:	70% 27% 0% 1% 2%
• Living Situation at Time of Referral	Family Home: Group Home: Psychiatric hospital: State Facility:	26.26% 57.58% 7.07% 4.04%
• Multiple residential placements in Past 5 Years	No: Yes:	58.77% 41.23%
• One or More psychiatric hospitalizations in past year	No: Yes:	62.28% 37.72%
• One or More psychiatric hospitalizations in the past 1-5 years	No: Yes:	 50.88% 49.12%
• Legal Guardian	No: Yes:	66.67% 33.33%
• Psychiatric Diagnosis	% with at least one diagnosis: % with 1 diagnosis: % with 2 diagnoses: % with 3 diagnoses: Mood Disorders: Psychotic Disorders: Anxiety: Autism: Childhood disorders: Impulse Control D/O: Other:	68.57% 68.06% 18.06% 13.89% 55.56% 26.39% 13.89% 13.89% 11.11% 6.94% 6.94%

	Personality Disorders:	2.78%
• Physical Disabilities	Hearing: Physical: Speech: Vision:	3 2 2 2
• Medical Diagnoses	% of Individuals who have Medical Diagnoses: % with 1 diagnosis: % with 2 diagnoses: % with 3 diagnoses: % with 4 or more diagnoses:	64.62% 61.90% 23.81% 11.90% 2.38%
• Incarceration	% of individuals w/one or more jail stays in last year: % of individuals w/one or more jail stays in the past 1-5 years:	6.25% 11.34%

The majority of individuals served in Region IV's START program in FY 13 were young adults in their mid-twenties presenting with mild to moderate intellectual disability and with one or more psychiatric and medical diagnoses. The oldest individual served was 69 years old and the youngest 18 years old. A nearly equal number of male and female clients were served during this time frame. Most of the individuals have the ID Waiver as their funding source with the second most predominant funding source being Medicaid without an ID Waiver. Of those served, only 9 individuals were reported to have a physical disability. The majority of those served were their own legal guardian. More than half of those served had at least one medical condition. Eleven percent of START referrals had experienced an incarceration in the past 1-5 years and 6.25% had been incarcerated in the past year.

C. Services Provided:	
• Emergency/Crisis Services	123; First date of service: 9/5/2012
• Emergency Respite	Not yet providing
• Planned Respite	Not yet providing
• In-Home Respite	14; First date of service: 3/7/2013

Region IV has been providing Emergency/Crisis supports and In-Home Respite (Mobile) supports since March 7, 2013. The program encountered difficulties this year related to selected location of the Respite House. Unfortunately the START program was unable to obtain the necessary permits to renovate the home purchased for the respite program. A search for a new site then ensued. A site was identified and a one-year lease has been signed and will be effective July 1, 2013. Significant renovations were deemed necessary in order to ensure that the site is functional and safe for the delivery of respite supports. These renovations are underway with a planned date of completion by mid-September 2013. The site that has been identified is at this point considered a temporary location for the respite services to be delivered.

D. Assessments and Plans:	
• Crisis Plans Completed	92 – Provisional Plans 31 – Cross Systems Crisis Plans
• Comprehensive Service Evaluations	3
• Clinical Education Teams	0
• ABC's conducted	97
• MED's conducted	0 – N/A
• Consultations to system by Medical Director	24
• Admission / Discharge Summaries written by Respite Director	Admission Summaries: 14 Discharge Summaries: 12

Region IV has been working hard to process new referrals that come in while continuing to serve those who were referred all at one time when the program first opened. This has been a challenge however the system is working hard to ensure that every open client has a crisis plan and is receiving the appropriate level of support based on their needs. Region IV will begin implementing START Action Plans for all referrals in the upcoming Fiscal Year to help guide clinical practice and individualize the supports that are being provided.

E. Training Provided:		
Emergency Services	D19 CSB Emergency Services	7/12/2012, 2/5/2013
	Southside CSB Emergency Services	6/07/2012
	Crossroads CSB Emergency Services	1/24/2013
	Henrico Emergency Services	1/30/2013
	Hanover CSB Emergency Services	2/7/2013
	RBHA Emergency Services	1/09/2013, 1/10/2013, 1/16/2013
	RBHA Regional Crisis Stabilization Unit	1/23/2013
	Goochland Powhattan Emergency Services	1/09/2013
	Chesterfield ID/Emergency Services	1/22/2013, 2/19/2013
Community Based Provider Orientation	Good Neighbor, VABODE, Phoenix-N-Peace, Richmond Residential, Compassionate Hearts Family Services, Legacy Family Services, St. Joseph's Villa, Serenity C&C, and Diversity @ Henrico	6/28/2012
	Safe Haven, Teen Option, Good Neighbor, Lutheran Family Services, Kristie's Family Care, St. Joseph's Villa, Intercept @ Henrico	6/25/2012
Program Coordinator Orientation	Hanover CSB	1/24/2013

In FY 13, Region IV provided training to providers and local CSB's on the START model and supports. The program focused this year on assessing the needs of the system and identifying gaps in service delivery and will be working in FY 14 to further develop collaborative relationships that will impact the I/DD system by providing more options and access to emergency services for individuals experiencing crisis and / or challenging behaviors.

F. Affiliation Agreements	Date of Agreement
• Richmond Behavioral Health Authority	9/05/12
• District 19 CSB Emergency Services	10/25/12
• Henrico Area Mental Health & Developmental Services, Emergency Services Program	10/12/12
• Chesterfield CSB Emergency Services	8/27/12

G. Goals for FY 14
• Complete START Action Plans for all individuals referred
• Increase amount of community training provided
• Fully operational regional program
• Improve community relations with Region IV START Stakeholders
• Open Respite House and begin delivering Emergency and Planned Respite
• Support all Coordinators / Clinical staff in becoming certified
• Work collaboratively with local community, other regional START Programs, START Manager at DBHDS, and National START Consultant
• Work with community stakeholders to address gaps in crisis services with the closing of Southside Virginia Training Center in 2014
• Work with Regional Support Teams (RSTs) to address barriers to providing optimal services to individuals in the community

Completed by:
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Attachment 8: Region 5 Report

THE CENTER FOR START SERVICES

A program of the Institute on Disability/UCED, University of New Hampshire

Virginia START
Systemic Therapeutic Assessment Respite and Treatment

HPR V

Virginia START

Annual Report
On Services Delivered
July 1, 2012-June 30, 2013

A program of the Institute on Disability/UCED, University of New Hampshire

Background

The Hampton Newport News Community Services Board serves as the lead agency for the HPR V START Program. The HPR-V serves nine communities, Hampton- Newport News, Portsmouth, Norfolk, Virginia Beach, Colonial Behavioral Health, Chesapeake, Middle Peninsula Northern Neck, and Eastern Shore. The primary stakeholder agencies of the START program are the Community Services Boards, who represent the individuals and families of the region and provide case management services to those referred. Additionally, many other private agencies, families, and advocates in the community have been actively involved in the implementation process of START and serve on our region's advisory committee. The original proposal for the START program was authored by the ID Directors of Region V.

Challenges in start-up

One of the major challenges has been significant turn over in the management staff. We are recruiting for our second START Director and the second Clinical Director has been in the position for less than six months. Additionally, we are currently recruiting for our third Respite Manager. Despite staff turn over the program is aggressively moving forward. Dr. Lori Burkett, LCP is currently serving has the Interim Director and Clinical Director. She has the assistance of two HNNCSB Residential Clinical Administrators managing the respite center while recruitment efforts are under way. Recruitment of START staff is ongoing and we currently have hired the following staff: one Team Leader, five START coordinators, three respite counselors, and three respite support staff. Remaining staff position to fill include, one Team Lead, one START coordinator, three part-time respite counselors, four on-call respite counselors, and three respite support staff.

Another challenge has been the delay in the development of the respite site. The original home was purchased in 2012 shortly after the grant was awarded. Upon touring the home, the national consultant advised that the home's layout was not conducive to the START model. Following extensive planning and the approval of plans by all involved parties to build a new home on the same property, it was determined to be cost prohibited. Thus, it was decided to renovate the existing home. After several delays with building permits and construction processes, the home is now under renovation and scheduled to be completed by the end of September 2013. The goal is to have the home set up and licensed for services by the end of October.

In the interim, Region V has been granted permission to use a temporary site at Southeastern Virginia Training Center, SEVTC, until the end of October. The training center leadership and staff have been of tremendous assistance in setting up the temporary cottage. Although this has created dual effort, it is has been an opportunity to move forward and train the staff in providing START services. The home has been licensed, and the majority of the staff has been hired. An

aggressive training regime in underway for both clinical and respite staff. We are currently screening 22 referrals for planned Respite. Implementation of respite services at the temporary site have begun in a stepwise fashion. Following a recent training provided by our national consultant, elements of the home need to be reorganized. This led to the revamping and moving of our sensory room and program area.

Although there have been many challenges during the implementation process, START HPV 5 has celebrated as many successes. Stakeholder's concerns that START leadership has placed the fidelity of the START Model before timely services in the region have been addressed. Through monthly ID Director meetings, advisory council meetings, community outreaches, regional oversight committees and MH/SA Councils, stakeholders and families have been assured of START HPV 5's commitment to the quality of individual services provided through the START Model. A START handbook for stakeholders was developed to educate community providers on how best to access START services. Information was included related to quality assurance, making referrals, and receiving additional supports. The feedback on this outreach effort has been favorable. Understanding that stakeholders may be inclined to focus on respite services, an effort has been made to educate the community on the importance of the START Model related to community outreach and providing interventions in the community. With this increased communication, stakeholders are beginning to embrace community efforts with utilization of out of home placements as a last resort. As noted in the data that follows, START HPV 5 is providing 24/7 mobile crisis intervention across our region, in-home supports, systemic education and coordination, and assessment services.

Client Data

The following represents data from referrals received from July 1, 2012 through June 30, 2013. There were a total of 104 client records entered into the SIRS system during this time period. Of these referrals, only one was not accepted for START services due to not meeting eligibility criteria and was referred to other non-START services.

It should be noted that the region is behind in SIRS data entry to date. Of the 104 client records, 14 are lacking aspects of data that prohibit inclusion in data analysis. Subsequently, the region is able to report on 90 client records. With this said, efforts have been under way to ensure that data is up to date and this is a primary goal for the first quarter of fiscal year 2014. The following data provides key information based on the population served by HPR V START in FY13 and appears to be an accurate representation of the population served in spite of not all data on every client being entered into SIRS at the time of this report.

Client Information

Gender

As indicated in the table below, the region has received more referrals for males than females.

Gender	Number	%
Female	35	38.89%
Male	55	61.11%
Total		100.00%

Age

The age range of referrals was 18-71 years with an average age of 34 years. However, it should be noted that the most common age reported (mode) was 27 years.

Age	Descriptive Statistics for Individuals by Age
Oldest Age	71
Youngest Age	18
Mean Age	33.83
Median Age	30
Mode Age	27

Legal Guardian

As noted below, 66% of individuals within the region serve as their on legal guardian.

Legal Guardian	Number	%
No	59	65.56%
Yes	31	34.44%
Total	90	100.00%

Level of Intellectual Disability

The majority (84.27%) of individuals referred to START in HPR V had a diagnosis of mild to moderate intellectual disability.

Level of Intellectual Disability	Number of Individuals by level of ID reported	Percent of Individuals by level of ID reported
Normal Intelligence	1	1.12%
Borderline	2	2.25%
Mild	44	49.44%
Moderate	31	34.83%
Severe	10	11.24%
Profound	1	1.12%
Total	89	100.00%

Mental Health Diagnoses at the Time of Referral

Of the 90 individuals entered into the database, a total of 53 (63.10%) had mental health diagnoses reported. It is noteworthy that 38% had a diagnosis of Mood Disorder, 30% a diagnosis of a Psychotic Disorder, and 23% a diagnosis of Autism. The distribution of diagnoses is consistent with other START populations in the U.S. where the primary issues are mood and anxiety disorders. It is also noteworthy that 37 individuals reported no mental health diagnosis. This presents as a significant finding and one to be monitored closely over the next several quarters.

Psychiatric Diagnosis	Number of individuals by current psychiatric diagnoses reported	Percent of individuals by current type of psychiatric diagnosis reported
Anxiety-all	8	15.09%
Autism-all	12	22.64%
Childhood-all	7	13.21%
Mood-all	20	37.74%
Psychotic—all	16	30.19%
Adjustment disorder	3	5.66%
Eating disorder	0	0.00%
Fictitious/Somatoform	0	0.00%
Impulse Control Disorder	2	3.77%
Personality disorder (Axis II)	0	0.00%
Sexual/Gender Identity	0	0.00%
Substance Abuse Disorder	1	1.89%
Other	14	26.42%
Total Diagnoses Reported	83	26.42%

Total individuals with reported psychiatric diagnoses	53	63.10%
Mean diagnoses reported	1.58	n/a
Mode diagnoses reported	1	n/a
1 diagnosis reported	30	33.33%
2 diagnoses reported	16	17.78%
3 diagnoses reported	6	6.67%
4 diagnoses reported	1	1.11%
5 diagnoses reported	0	0.00%
Total individuals reporting no diagnosis	37	41.11%

Other Disabilities Reported at the Time of Referral

Other disabilities reported notes particular vulnerabilities that may be present for individuals served by HPR V START. It will be important to watch for trends in order for consideration of these vulnerabilities to be included in future reporting and planning.

Other Disabilities	Number of individuals by current disabilities reported	Percent of individuals by current disabilities reported
Hearing	3	16.67%
Physical/ambulation	2	11.11%
Smell	0	0.00%
Speech/Communication	8	44.44%
Vision	1	5.56%
Other	4	22.22%
Total Individuals reported	**18**	**100.00%**

Medical Diagnoses at the Time of Referral

Data regarding medical issues will be important to track over time as the region monitors the medical needs of individuals in the community and seeks to fill gaps in services available and potential shortages of service providers in some communities within the region for this population. Noteworthy in the table below is that 37% of individuals reporting a medical diagnosis had a gastrointestinal condition and another 39% had a neurologic condition. The other most common medical diagnosis reported was cardiovascular. It is noteworthy that 37% of individuals reported other medical conditions. It is unclear as to whether the information was unavailable at the time or whether there was error in reporting. This presents as a significant finding and one to be monitored closely over the next several quarters in an effort to ascertain clarification of these medication conditions.

Medical Diagnosis	Number of individuals by current diagnosis reported	Percent of individuals by current diagnosis reported
Cardiovascular	6	14.63%
Dental/Oral	1	2.44%
Dermatology/Skin	1	2.44%
Ear/Nose/Throat	2	4.88%
Endocrine	0	0.00%
Eye Disorders	1	2.44%
Gastro/Intestinal	15	36.59%
Genitourinary	1	2.44%
GYN/Pregnancy	0	0.00%
Hematology/Oncology	0	0.00%
Hepatic/Biliary	1	2.44%
Immunology/Allergy	0	0.00%
Infectious disease	0	0.00%
Neurologic	16	39.02%
Nutritional disorders	0	0.00%
Pulmonary disorders	4	9.76%

Other	15	36.59%
Total Diagnoses Reported	63	

Noteworthy in the table below is that 54% of individuals reported no medical diagnosis at the time of referral. It is unclear whether this information was unavailable at the time of referral or whether this indicates some other variable to be determined. Chronic medical conditions can have a large impact on psychological well-being and it will be important to develop an accurate picture of the nature and prevalence of medical diagnoses in the population served by HPR V START.

Medical Diagnosis	Number of individuals by current diagnosis reported	Percent of individuals by current diagnosis reported
Total individuals with reported medical diagnoses	41	45.56%
Mean diagnoses reported	1.59	n/a
Mode diagnoses reported	1	n/a
1 diagnosis reported	27	30.00%
2 diagnoses reported	7	7.78%
3 diagnoses reported	5	5.56%
4 diagnoses reported	1	1.11%
5 or more diagnoses reported	1	1.11%
Total individuals reporting no diagnosis	49	54.44%

Residential Information

Residential Setting at Time of Referral

At the time of referral the majority of individuals in HPR V were living either in a group home (43%) or in their family home (34%).

Living situation at time of referral to START	Number of individuals by type of living situation reported	Percent of individuals by type of living situation reported
Assisted Family Living (ALF)	0	0.00%
Community ICF/MR	0	0.00%
Family Home	30	33.71%
Foster Care Home	0	0.00%
Group Home	38	42.70%
Homeless	3	3.37%
Independent Living	4	4.49%
Jail	0	0.00%
Psychiatric Hospital	3	3.37%

State operated training center	0	0.00%
Supervised Apartment	6	6.74%
Supported Living	1	1.12%
Other	4	4.49%
Total	**89**	**100.00%**

As noted in the chart below, 31% of the individuals served by the region have had multiple residential placements over the 5 years prior to referral to START. Instability in housing and lack of permanence is something that should be monitored.

Multiple residential placements over the last 5 years at point of referral	Number of individuals with multiple placements	Percent of individuals with multiple placements
No	62	68.89%
Yes	28	31.11%
Total	90	100.00%

Psychiatric Hospitalizations

A significant number of START service recipients in the region have been admitted to psychiatric hospitals in the past year.

Psychiatric hospitalizations in the last year (at point of referral)	Number of individuals reporting one or more hospitalizations in the last year	Percent of individuals reporting one or more hospitalizations in the last year
No	64	71.11%
Yes	26	28.89%
Total	**90**	**100.00%**
Range	1 - 5	
Mean	1.77	

Psych hospitalizations in the last 1-5 years (at point	Number of individuals reporting one or more	Percent of individuals reporting one or more

of referral)	hospitalizations in the last 1 - 5 years	hospitalizations in the last 1 - 5 years
No	61	67.78%
Yes	29	32.22%
Total	**90**	**100.00%**
Range	1 -20	
Mean	3.14	

Number of Prior Psych Hospitalizations	Total number of hospitalizations	Percent of prior psychiatric hospitalizations
In past 1 to 5 years	91	66.42%
In past year	46	33.58%
Total	**137**	**100.00%**

Services Provided

Emergency/Crisis Services

The program began providing 24/7 emergency response and crisis intervention services in January of 2012. According to SIRS data, between January and June of 2013, the program responded to 75 emergency/crisis referrals involving 43 individuals throughout the region. Eleven of these individuals (26%) were referred for more than one crisis contact. There is some discrepancy between the SIRS report and program hand tallied data regarding the number of crisis/emergency responses. This may be due to the fact that the Coordinators have had difficulty entering data into SIRS system. The program likely responded to more than the 75 referrals recorded in SIRS.

Crisis Referral Source

The majority of emergency/crisis referrals were from family members (42.25%). Also noteworthy are the number of emergency/crisis referrals from residential providers (18.31%) and emergency services (19.72%). Requests to provide training for area providers has increased.

Most notably, family members have asked for support services (i.e. a family/parent support group and assistance with implementing interventions/services with their loved one).

Source of Contacts/Referrals for Services	Number of Sources	Percent of Sources
Case Manager/Service Coordinator	8	11.27%
Community psychiatric inpatient	1	1.41%
Emergency services/Mobile crisis team	14	19.72%
Day/Vocational service provider - Community	2	2.82%
Family member	30	42.25%
Friend	1	1.41%
Hospital emergency department	0	0.00%
Law enforcement	0	0.00%
Legal advocate	0	0.00%
Residential provider - Community	13	18.31%
School	0	0.00%
Self	2	2.82%
State operated I/DD center	0	0.00%
State psychiatric hospital	0	0.00%
Other	0	0.00%
Total	**71**	**100.00%**

Problems reported at the time crisis contact

Data indicated that the primary problem reported at the time of crisis is aggression followed by mental health symptoms, family needing assistance, and decrease in ability to participate in daily functions. Approximately 8% of referrals for a crisis were at risk of losing their placement.

Presenting problems at time of referral to emergency/crisis services	Number of Problems	Percent of Total Problems Reported	Number of Individuals Reporting Problems	Percent of Individuals Reporting Problems
Aggression - all	88	45.13%	34	33.33%
Mental health symptoms - all	42	21.54%	23	22.55%
At risk of losing placement	15	7.69%	9	8.82%

Decrease in ability to participate in daily functions	11	5.64%	9	8.82%
Diagnosis and treatment plan assistance	4	2.05%	3	2.94%
Family needs assistance	14	7.18%	7	6.86%
Self-injurious	9	4.62%	7	6.86%
Transition from hospital	1	0.51%	1	0.98%
Other	11	5.64%	9	8.82%
Total presenting problems	**195**	**100%**		**100%**

Reported response time following emergency request

On average, the region was able to meet the required response time of less than two hours. This is in spite of turnover in Coordinator positions and managing the on-call for the large geographic region. The region anticipates being able to meet the two hour requirement in FY14.

Response time	Number of events by response time	Percent of events by response time
Less than 2 hours	57	93.44%
2 hours or more	4	6.56%
Average response time	1 hour(s), 4 minute(s)	

Outcomes/primary dispositions during the crisis contact

There were a variety of dispositions reached on individuals when a crisis response was made. Approximately 15% of individuals referred through a crisis contact were admitted for a community mental health in-patient unit admission. Notably, 69% of individuals referred through a crisis contact were maintained in the current setting.

The region continues to find getting a disposition on individuals needing a higher level of care in a crisis challenging. A number of behavioral health units have refused admission for individuals with intellectual disabilities, so there have been times when individuals have spent more than 24 hours in emergency rooms waiting for a disposition. While in emergency rooms, coordinators have provided support to the individual and their family/providers. We foresee the opening of our START Center (24 hours) within the next month to be an added resource to our community. This will be an area of focus for the coming year.

Final outcome/disposition of referral to emergency/crisis services	Number of Outcomes	Percent of Total Outcomes
Community mental health in-patient unit admission	11	15.49%
Crisis stabilization unit/bed	0	0.00%
In-home respite support	2	2.82%
Maintain current setting	49	69.01%
Referral out for services	0	0.00%
START emergency respite admission	0	0.00%
START planned respite scheduled/provided	0	0.00%
State operated/private ICF/MR or other I/DD facility	0	0.00%
State psychiatric hospital admission	6	8.45%
Other	3	4.23%
Total outcomes	**71**	**100.00%**
Total individuals with reported final outcome/disposition	**42**	

Emergency Respite
Not yet providing this service. The permanent START Center is due to be open in October 2013. This will be an area of focus for the coming year.

Planned Respite
HPR V did not provide this service during the reporting timeframe. However, the START Center opened on August 2nd and provided planned respite to one individual during the month of August 2013.

In-Home Respite
HPR V did not provide this service during the reporting timeframe. However, in-home supports were provided to three individuals during the month of August 2013. This will be an area of focus for the coming year.

Additional START Clinical Team Services
The START clinical team has been able to provide a variety of START services throughout the region during the past year. The primary challenge on the clinical team is the lack of a Team Leader and the turnover in Coordinator positions. At the time of this report, the Director, Respite Manager, one Team Leader, and one coordinator position are vacant. Multiple staff have been hired over the last two months (respite and clinical). Filling vacant positions is a primary goal for the coming year.

The Clinical Team provided a variety of assessment services. During the past year the following were completed:

Type of Assessment/Plan	Number Completed
Provisional Crisis Plan	90

Cross System Crisis Plan (CSCP)	62 completed (18 in draft form)
Comprehensive Service Evaluation (CSE)	3
Aberrant Behavior Checklist (ABC)	111
MED	0
Consultation to system provided by Medical Director	Services began on 3/8/2013
Admission/Discharge summaries written by Respite Director	0

List of Affiliation and Linkage Agreement Completed

START HPV 5 has started the process of developing Linkage Agreements with area Emergency Services Departments in the Region. Finalization of these agreements will be a focus of the coming months.

Goals for FY14

GOAL	ACTION STEPS	TARGET DATE OF COMPLETION
Ongoing Staff recruitment	Work with Human Resources Department to continue to prioritize ongoing START recruitment and weekly interview sessions. Post vacant positions on DBHDS web site	on-going as needed September 2013
Decrease employee turnover	Respond to staff requests to do team building activity Provide more regular staff supervision Include employees in decision making Provide more work site support	September 30, 2012 and Ongoing
Ensure that data entry into SIRS is up to date and accurate in order for the region to be able to accurately track trends and outcomes and assess performance measures	START Director and Clinical Director will work together to direct START Coordinators and Clinical Team to enter data into SIRS in a timely and accurate manner.	September 15, 2013 and ongoing
Secure signed Linkage Agreements with regional stakeholders to strengthen	Set up individual meetings with designated stakeholders and provide START update, request signed	March 30, 2014, and ongoing

the system's collaboration, ownership, knowledge of the START Services	agreement from CSB Emergency Service, Eastern State Hospital, H-NN, Norfolk and VB Crisis Stab units, and designated private providers.	
Improve relationship with stakeholders, by increasing understanding of and responsiveness to identified needs of the region, Identify GAPs in START services	Satisfaction surveys Continue to meet with ID Council monthly, Continue quarterly regional Advisory committee meetings Schedule individual meetings with each CSB to discuss needs and ways to improve START services Continue to participate in regional oversight committees and MH/ID Council meetings to address systemic gaps in crisis services	December 2013 and ongoing
Implement second START Team, to cover half the region, develop Southside and Peninsula teams	Hire 2 team Leaders Fill vacant coordinator positions, for total of 10 Secure Southside office space	November 2013
Fully Implement the START respite Center	Provide 24/7 respite services Continue to hire and train respite staff Operationalize permanent site	September 2013 End of October 2013
Provide In Home Services	Hire & train additional staff in order to be able to provide respite and in home services simultaneously	October 2013
Increase clinical skills of Coordinators, Clinical Team and Respite Staff	Participate in ongoing training with START National consultants and in collaboration with Region Pursue having START Coordinators complete other state training such as Emergency Services certification training	Current and ongoing 1/15/14

	Have START Coordinators attend PBS training where possible	As available
Hire local Medical Director closer to Respite Center	Work with HNNCSB Medical Director to secure a permanent Medical Director in close proximity to the Hampton Respite center. Continue relationship with existing Medical Director from Region one until local Medical Director is hired.	Current and ongoing